CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 446 **Date: JANUARY 21, 2005**

CHANGE REQUEST 3637

NOTE: Transmittal 409 Dated December 21, 2004 is rescinded and replaced with Transmittal 446, Dated January 21, 2005.

SUBJECT: Diabetes Screening Tests

I. SUMMARY OF CHANGES: Expanded Medicare coverage of certain diabetes screening tests is mandated by section 613 of the Medicare Prescription Drug Improvement and Modernization Act of 2003. This section provides guidance and clarification of the new rules for diabetes screening tests effective for services performed on or after January 1, 2005. See 42 CFR 410.18, added by 69 FR 66236, 66421 (November 15, 2004).

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2005
IMPLEMENTATION DATE: January 3, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:(N/A *if manual not updated.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 446	Date: January 21, 2005	Change Request 3637

NOTE: Transmittal 409 Dated December 21, 2004 is rescinded and replaced with Transmittal 446, Dated January 21, 2005.

SUBJECT: Diabetes Screening Tests

I. GENERAL INFORMATION

A. Background: Section 613 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) mandates coverage of diabetes screening test, effective for services furnished on or after January 1, 2005, for beneficiaries at risk for diabetes.

B. Policy: The CMS issued regulations to conform to the MMA, and have specified coverage of diabetes screening tests at 42 CFR 410.18. (See 69 FR 66421, November 15, 2004.) Diabetes screening tests are defined as testing furnished to an individual at risk for diabetes, including: (1) a fasting blood glucose test, and (2) a post-glucose challenge (an oral glucose tolerance test with a glucose challenge of 75 gms. of glucose for non-pregnant adults, or a 2-hour post-glucose challenge test alone). The MMA also allows other tests as the Secretary deems appropriate after consultation with appropriate organizations.

Two screening tests per year are covered for individuals diagnosed with pre-diabetes. One screening per year is covered for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested. Medicare will pay for diabetes screening tests under the Medicare Clinical Laboratory Fee Schedule. To indicate that the purpose of the test(s) is for diabetes screening, a screening diagnosis code V77.1 is required in the header diagnosis section of the claim. When the test is performed on individuals diagnosed with pre-diabetes, both the screening diagnosis code V77.1 AND modifier "TS" – follow-up service are required. (CMS will issue subsequent instructions that provide additional billing guidance for the billing of diabetes screening for the pre-diabetic beneficiary. In addition, effective, April 1, 2005, the modifier "TS" will be valid for Medicare.)

Individuals who have any of the following risk factors for diabetes are eligible for this benefit:

●Hypertension,
●Dyslipidemia,
●Obesity (a body mass index equal to or greater than 30 kg/m2), or
●Previous identification of elevated impaired fasting glucose or glucose intolerance.

Or, individuals who have a risk factor consisting of at least 2 of the following characteristics are eligible for this benefit:

- Overweight (a body mass index > 25, but < 30 kg/m2),
- A family history of diabetes,

- Age 65 years or older,
- A history of gestational diabetes mellitus, or delivering a baby weighing > 9 lbs.

No coverage is permitted under the MMA benefit for individuals previously diagnosed as diabetic since these individuals do not require screening. Other diabetes screening blood tests for which CMS has not specifically indicated national coverage continue to be non-covered.

Definitions: Diabetes: diabetes mellitus, a condition of abnormal glucose metabolism diagnosed from a fasting blood sugar > 126 mg/dL on 2 different occasions; a 2-hour post-glucose challenge > 200 mg/dL on 2 different occasions; or a random glucose test > 200 mg/dL for an individual with symptoms of uncontrolled diabetes.

Pre-diabetes: abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to125 mg/dL, or a 2-hour post-glucose challenge of 140 to 199 mg/dL. The term "pre-diabetes" includes impaired fasting glucose and impaired glucose tolerance.

Post-glucose challenge test: oral glucose tolerance test with a glucose challenge of 75 gms. of glucose for non-pregnant adults, or a 2-hour post-glucose challenge test alone.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters. You will receive notification of the article release via the established "Medlearn Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin following availability of such article. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3637.1	Contractors shall accept CPT code 82947-Glucose; quantitative, blood (except reagent strip) when the diagnosis code reported is V77.1	x		x		x	x	x		

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3637.2	Contractors shall accept CPT code 82950- post glucose dose (includes glucose) when the diagnosis code reported is V77.1	x		x		x	x	x		
3637.3	Contractors shall accept CPT code 82951- tolerance test (GTT), three specimens (includes glucose) when the diagnosis code reported is V77.1	x		x		x	x	x		
3637.4	The NCD Edit Module for Clinical Diagnostic Laboratory Services shall be revised. CPT code 82947, when billed with diagnosis code V77.1, shall be listed as a covered ICD-9 code.					X				NCD Edit Module
3637.5	The Outpatient Code Editor shall be revised to permit payment for 82947, 82950 and 82951 when billed with diagnosis code V77.1									Outpatient Code Editor
3637.6	The CWF shall allow codes 82947 and 82951 no more than once every 6 months when billed with diagnosis code V77.1								X	
3637.7	Contractors shall deny claims for 82947 and 82951 upon receipt of a CWF reject that indicates the dates of service are more frequent than 2 screening tests per year for individuals diagnosed with pre-diabetes. NOTE: Contractors shall use MSN 16.25: Medicare does not pay for this much equipment, or this many services or supplies or 18.4 This service is being denied because it has not been 6 months since your last examination of this kind	x		x		X				
3637.8	Contractors shall pay for Diabetes Screening Tests only when the services are submitted on one of the following type bills (TOBs): 12X, 13X, 14X, 22X, 23X, 85X	X				X				

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3637.8.1	Contractors shall pay TOBs: 12X, 13X, 14X, 22X, 23X under the Clinical Laboratory Fee Schedule	X				X				
3637.8.2	Contractors shall pay for Critical Access hospitals TOB 85X on reasonable cost	X				X				
3637.9	Contractors shall pay for Diabetes Screening Tests in Maryland Hospitals, on a Part B claims basis (TOB 12X, 13X, 85X) according to the Maryland State Cost Containment plan	X				X				

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions
3412.2, 3412.5	CMS will issue subsequent instructions that provide additional billing guidance for the billing of diabetes screening for the pre-diabetic beneficiary.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2005 **Implementation Date:** January 3, 2005 **Pre-Implementation Contact(s):** Betty Shaw 410-786-4165 (coverage), Taneka Rivera 410-786-9502 (FI), Joan Proctor-Young 410-786-0949 (carrier), Danford Layne 410-786-3320 (labs) **Post-Implementation Contact(s):** Same	**Medicare contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**