CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12694	**Date: June 21, 2024**
	Change Request 13487

Transmittal 12600 issued May 02, 2024, is being rescinded and replaced by Transmittal 12694, dated June 21, 2024, to correct an Outpatient consistency edit in Business Requirement (BR) 13487 - 04.7, as well as to provide clarifications and instructions to the MACs on claims processing prior to the implementation date of this CR. In addition, this correction updates the Effective and Implementation dates, updates the Policy section and revises BRs 13487 - 04.1, 13487 - 04.2.1, 13487 - 04.9 and 13487 - 04.11. This correction does not make any revisions to the companion Pub. 100-02; all revisions are associated with Pub. 100-04. All other information remains the same.

SUBJECT: Expand Diabetes Screening and Diabetes Definitions Policy Update in the Calendar Year 2024 Physician Fee Schedule Final Rule - This CR Rescinds and Fully Replaces CR 13487.

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to make contractors aware of policy updates for diabetes screening and diabetes definitions resulting from changes specified in the Calendar Year (CY) 2024 Physician Fee Schedule (PFS) Final Rule (88 FR 78818), published in the Federal Register on 11/16/2023.

EFFECTIVE DATE: January 1, 2024 - Per CY 2024 PFS policy effective date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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 is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/300/300.1 Beneficiaries Eligible for Coverage and Definition of Diabetes

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-02	Transmittal: 12694	Date: June 21, 2024	Change Request: 13487

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to make contractors aware of policy updates for diabetes screening and diabetes definitions resulting from changes specified in the Calendar Year (CY) 2024 Physician Fee Schedule (PFS) Final Rule (88 FR 78818), published in the Federal Register on 11/16/2023.

Diabetes is a chronic disease that affects how the body turns food into energy. Screening is performed on persons who may not exhibit symptoms to identify persons with either prediabetes or diabetes, who can then be referred for appropriate prevention or treatment, with the intention of improving health outcomes.

Under Medicare policy prior to January 1, 2024:

- **Tests**- two screening tests were authorized for diabetes screening, including
  - The Fasting Plasma Glucose (FPG) test, (HCPCS Code 82947, Glucose; quantitative, blood (except reagent strip))
  - The Post Glucose Challenge Test, also called the Glucose Tolerance Test (GTT), HCPCS Codes 82950, Glucose; post glucose dose (includes glucose) and 82951, Glucose; tolerance test (GTT), 3 specimens (includes glucose))
  - **Note**: the Hemoglobin A1C (HbA1c) test (HCPCS code 83036) was covered for purposes of diabetes management but not for diabetes screening.
- **Frequency Limitations**- allow two screening tests per calendar year if the patient was previously diagnosed with pre-diabetes and one screening test per year for patients who were previously tested who were not diagnosed with pre-diabetes, or who were never tested before. Pre-diabetes was defined in regulations as “pre-diabetes means a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting glucose level of 100–125 mg/dL, or a 2-hour post-glucose challenge of 140–199 mg/dL. The term pre-diabetes includes the following conditions:
  - (1) Impaired fasting glucose.
  - (2) Impaired glucose tolerance.”
- **Definition-** the regulatory definition of “diabetes” for purposes of screening, Medical Nutrition Therapy (MNT), and Diabetes Outpatient Self-Management Training Services (DSMT) included a clinically specific test-based definition for “diabetes.” The regulatory text read, “diabetes means diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a 2-

hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes."

Regulations on Diabetes Screening coverage can be found at 42 CFR 410.18.

Regulations on MNT coverage can be found at 42 CFR Part 410 Subpart G and 42 CFR 410.130.

Regulations on DSMT coverage can be found at 42 CFR Part 410 Subpart H and 42 CFR 410.140.

B. Policy: Effective January 1, 2024, Medicare policy includes the following updates:

- **Tests-** in addition to the FPG and GTT tests already authorized for diabetes screening (see above), Medicare now also covers the HbA1c test for diabetes screening. Note: beneficiary coinsurance and deductible do not apply to the HbA1c test when furnished for diabetes screening because the U.S. Preventive Services Task Force (USPSTF) August 2021 Final Recommendation Statement on Diabetes Screening includes the HbA1c test (Grade B).
- **Frequency Limitations**- diabetes screening frequency limitations are now simplified to not more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual (for qualified beneficiaries). Medicare no longer distinguishes diabetes screening frequency limitations based on a prior diagnosis of pre-diabetes. The regulatory definition of pre-diabetes has been removed from Medicare regulations.
- **Definitions-** the regulatory definition of diabetes for purposes of diabetes screening, MNT and DSMT have been simplified and now reads, "Diabetes means diabetes mellitus, a condition of abnormal glucose metabolism."

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13487 - 02.1	Contractors shall be aware of the policy updates regarding diabetes screening and diabetes definitions authorized in the CY 2024 PFS Final Rule, effective January 1, 2024, including the revised definition of diabetes for DSMT. See Publication 100-02, Chapter 15, Section 300.1.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13487 - 02.2	Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:N/A

V. CONTACTS

Pre-Implementation Contact(s): Daniel Feller, 410-786-6913 or daniel.feller@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

Table of Contents

(Rev. 12694; Issued 06-21-24)

300.1 - Beneficiaries Eligible for Coverage and Definition of Diabetes

(Rev. 12694; Issued: 06-21-24; Effective: 01-01-24; Implementation:10-07-24)

Medicare Part B covers 10 hours of initial training for a beneficiary who has been diagnosed with diabetes.

Diabetes is diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria;

- a fasting blood sugar greater than or equal to 126 mg/dL on two different occasions;

- a 2 hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or
  - a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Documentation that the beneficiary is diabetic is maintained in the beneficiary's medical record.

Beneficiaries are eligible to receive follow-up training each calendar year following the year in which they have been certified as requiring initial training or they may receive follow-up training when ordered even if Medicare does not have documentation that initial training has been received. In that instance, contractors shall not deny the follow- up service even though there is no initial training recorded.

Effective for claims with dates of service on or after January 1, 2024, "diabetes" means diabetes mellitus, a condition of abnormal glucose metabolism. The specific test-based clinical criteria described above is no longer included in the regulatory definition of "diabetes" for purposes of Diabetes Self-Management Training (DSMT) services at 42 CFR 410.140.