CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	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Transmittal 12600 issued May 02, 2024, is being rescinded and replaced by Transmittal 12694, dated June 21, 2024, to correct an Outpatient consistency edit in Business Requirement (BR) 13487 - 04.7, as well as to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	4/300- Medical Nutrition Therapy (MNT) Services
R	18/1/1.2 – Table of Preventive and Screening Services
R	18/90/90.1 - HCPCS Coding for Diabetes Screening
R	18/90/90.2 - A/B MAC (B) Billing Requirements
R	18/90/90.2.1- Modifier Requirements for Pre-diabetes
R	18/90/90.3- A/B MAC (A) Billing Requirements
R	18/90/90.3.1- Modifier Requirements for Pre-diabetes
R	18/90/90.4- Diagnosis Code Reporting
R	18/90/90.5- Medicare Summary Notices
R	18/90/90.6- Remittance Advice Remark Codes

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. 100-04	Transmittal: 12694	Date: June 21, 2024	Change Request: 13487

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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.

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

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."

Note: on March 14, 2024, CMS issued CR 13554 (Transmittal 12540) to update the Laboratory National Coverage Determination (NCD) Edit Software to allow for processing of the HbA1c test for diabetes screening (HCPCS 83036 with Z13.1 diagnosis code).

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13487 - 04.1	Effective for claims with dates of service on or after January 1, 2024, contractors shall accept and pay for the HbA1c test (HCPCS code 83036) as a covered test for diabetes screening when billed with diagnosis code Z13.1.	X	X			X				
13487 - 04.2	Effective for claims with dates of service on or after January 1, 2024, contractors shall accept claims for diabetes screening tests with HCPCS 82947, 82950, 82951, and 83036 and ICD-10-CM diagnosis code Z13.1, encounter for screening for	X	X			X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	diabetes mellitus reported in the header. NOTE: HCPCS codes 82947, 82950, 82951, and 83036 are allowable for multiple purposes, however, only ICD-10-CM diagnosis code Z13.1 is allowed for the screening of diabetes mellitus.									
13487 - 04.2.1	Contractors shall modify FISS reason code 31773 to allow HCPCS code 83036 when Z13.1 is present on 12X, 13X, 14X, 22X, 23X or 85X type of bill claims.					X				
13487 - 04.3	Contractors shall add HCPCS procedure code 83036 to existing edits (as applicable) that allow beneficiary deductible and coinsurance to not be applied to covered diabetes screening tests (as indicated by the Z13.1 code).	X	X							
13487 - 04.4	Effective for claims with dates of service on or after January 1, 2024, CWF shall modify edit 538T to reject an incoming Part B Professional claim or Outpatient claim with one of the HCPCS codes ‘82947’, 82950’, ‘82951’, or ‘83036’ with ICD-10-CM code Z13.1 and posted to the Screening Aux file are two screening test claims with HCPCS codes '82947’, or '82950’, or ‘82951’, or ‘83036’ and the incoming date of service is within 12 months of the posted screening services. *NOTE* - As of January 1, 2024, the ‘TS’ modifier no longer applies for diabetes screening services.					X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13487 - 04.4.1	Effective for claims with dates of service on or after January 1, 2024, contractors shall deny services that receive the CWF reject edit 538T and use the following messages: MSN 9.4 This item or service was denied because information required to make payment was incorrect. CARC: 119 - Benefit maximum for this time period or occurrence has been reached. RARC: N412 - This service is allowed 2 times in a 12-month period. Group Code: CO **NOTE**: Waiver of liability rules for beneficiaries should continue to apply on claims with dates of service on and after 1/1/2024 the same as they have for claims with dates of service prior to 1/1/2024. This includes adjudication rules for services billed with the 'GA' modifier.	X	X							
13487 - 04.5	The contractor shall end date Utilization edit 539D for Part B and outpatient and consistency edit 33#7 for Outpatient and 33x7 for Part B with End date of 12/31/2023.								X	
13487 - 04.6	Effective for claims with date of service on or after January 1, 2024, the contractor shall modify Part B consistency edit 33x6 to set if 3 or more screenings HCPCS 82947, 82950, 82951, or 83036 are present and the dates of service on the line items are within 12 months of each								X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	other.									
13487 - 04.7	Effective for claims with dates of service on or after January 1, 2024, contractor shall modify Outpatient consistency edit 33#6 to set if 3 or more screening HCPCS codes 82947, 82950, 82951, or 83036 are present and the dates of service on the line items are within 12 months of each other.								X	
13487 - 04.8	Contractors shall display the frequency limitation data on all the CWF provider query screens, including the next eligible date for HCPCS 83036 on the PRVN screen, HUQA and MBD/NGD extracts.					X	X		X	HETS, MBD, NGD
13487 - 04.9	CWF shall post HCPCS code 83036 to the PRVN screen and modify existing Rule code to state the following: Modified Rule Code: WHEN THE ICD-10 DIAGNOSIS CODE IS Z131 AND MODIFIER TS IS NOT PRESENT ALLOW EVERY 12 MONTHS, IF MODIFIER TS IS PRESENT ALLOW EVERY 6 MONTHS. Effective for claims with dates of service on or after January 1, 2024, when diagnosis code is Z13.1 present, allow not more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual (two screenings every 12 months from the date						X		X	HETS, MBD, NGD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	of the initial screening).									
13487 - 04.10	Contractors shall be aware of the definition change, effective January 1, 2024, of "diabetes" in Publication 100-02, Chapter 15, Section 300.1 for Diabetes Self Management Training (DSMT), in Publication 100-04, Chapter 4, Section 300 for Medical Nutrition Therapy (MNT), and in Publication 100-04, Chapter 18, Sections 90.2 and 90.3 for Diabetes Screening.	X	X							
13487 - 04.11	Effective for claims with dates of service on and after January 1, 2024, contractors shall not search claims but shall adjust claims brought to their attention.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13487 - 04.12	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 , Patricia Brocato-Simons, 410-786-0261 or patricia.brocatosimons@cms.hhs.gov (Primary contact beginning May 20, 2024.)

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

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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

300 - Medical Nutrition Therapy (MNT) Services

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

Section 105 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) permits Medicare coverage of Medical Nutrition Therapy (MNT) services when furnished by a registered dietitian or nutrition professional meeting certain requirements. The benefit is available for beneficiaries with diabetes or renal disease, when referral is made by a physician as defined in §1861(r)(l) of the Social Security Act (the Act). It also allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement for the first time. The effective date of this provision is January 1, 2002.

The benefit consists of an initial visit for an assessment; follow-up visits for interventions; and reassessments as necessary during the 12-month period beginning with the initial assessment ("episode of care") to assure compliance with the dietary plan.
Effective October 1, 2002, basic coverage of MNT for the first year a beneficiary receives MNT with either a diagnosis of renal disease or diabetes as defined at 42 CFR, 410.130 is 3 hours. Also effective October 1, 2002, basic coverage in subsequent years for renal disease is 2 hours.

For the purposes of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 36 months. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate (GFR) 15–59 ml/min/1.73m^2). Effective January 1, 2004, the Centers for Medicare & Medicaid Services (CMS) updated the definition of diabetes to be as follows: Diabetes is defined as diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar ≥ 126 mg/dL on two different occasions; a 2-hour post-glucose challenge ≥ 200 mg/dL on 2 different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes. *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 MNT at 42 CFR 410.130.*

The MNT benefit is a completely separate benefit from the diabetes self-management training (DSMT) benefit. CMS had originally planned to limit how much of both benefits a beneficiary might receive in the same time period. However, the national coverage determination, published May 1, 2002, allows a beneficiary to receive the full amount of both benefits in the same period. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full 3 hours of MNT. However, providers are not allowed to bill for both DSMT and MNT on the same date of service for the same beneficiary.

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

1.2 – Table of Preventive and Screening Services

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

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	***Not Rated**	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		Not Waived

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) services furnished prior to January 1, 2017	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	**B**	WAIVED
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) services furnished on or after January 1, 2017	76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	**B**	WAIVED
Cardiovascular Disease Screening	80061	Lipid panel	**A**	WAIVED
	82465	Cholesterol, serum or whole blood, total		WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		WAIVED
	84478	Triglycerides		WAIVED
Diabetes Screening Tests	82947	Glucose; quantitative, blood (except reagent strip)	**B**	WAIVED
	82950	Glucose; post glucose dose (includes glucose)		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**

	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	***B***	WAIVED
	83036	*Hemoglobin A1C Level*	***B***	*WAIVED*

Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	***Not Rated**	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Not Waived
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	**B**	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		WAIVED
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		WAIVED

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**

	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	**B**	WAIVED

	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		WAIVED
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	**A**	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	**A**	WAIVED

	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	**A**	WAIVED
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	**A**	WAIVED
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	**A**	WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	**A**	WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	**A**	WAIVED
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		WAIVED

	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		WAIVED
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	**A**	WAIVED
Screening Mammography	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	**B**	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)	**B**	WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	77063	Screening digital breast tomosynthesis, bilateral		WAIVED
	77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed		WAIVED

Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	**B**	WAIVED
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites, axial skeleton, (e.g., hips, pelvis, spine), including vertebral fracture assessment.		WAIVED

	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		WAIVED
NOTE: Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and coinsurance and deductible are waived. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the PT modifier; only the deductible is waived.				
Coinsurance and deductible are waived for moderate sedation services (reported with G0500 or 99153) when furnished in conjunction with and in support of a screening colonoscopy service and when reported with modifier 33. When a screening colonoscopy becomes a diagnostic colonoscopy, moderate sedation services (G0500 or 99153) are reported with only the PT modifier; only the deductible is waived.				
For dates of service in calendar year (CY) 2023 through CY 2026, when the PT modifier is appended to at least one code on the claim to indicate that a screening colorectal cancer procedure, HCPCS G0104, G0105, or G0121, has become a diagnostic or therapeutic service, contractors shall continue to waive deductible, and shall apply a reduced coinsurance of 15% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service in CY 2027 through CY 2029, contractors shall continue to waive deductible and shall apply a reduced coinsurance of 10% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service on or after January 1, 2030, contractors shall continue to waive deductible and shall waive coinsurance for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim.				
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	**A**	WAIVED
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		WAIVED

	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	***Not Rated**	Coins. Applies & Ded. is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		Coins. Applies & Ded. is waived

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	**A**	WAIVED
	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive		WAIVED
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		WAIVED
	81528	Oncology (colorectal) screening, quantitative real -time target and signal amplification of 10 DNA markers		WAIVED
	G0327	Colorectal cancer screening; blood-based biomarker Colon ca scrn;bld-bsd biomrk		WAIVED
	G0102	Prostate cancer screening; digital rectal examination	**D**	Not Waived

Prostate Cancer Screening	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	**I**	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived

Influenza Virus Vaccine		For the Medicare-covered codes for the influenza vaccines approved by FDA for current influenza vaccine season, please go to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html		
	90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	**B**	WAIVED

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	90653	Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use		WAIVED
	90654	Influenza virus vaccine, split virus, preservative free, for intradermal use, for adults ages 18-64		WAIVED

	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		WAIVED
	90657	Influenza virus vaccine, split virus, when administered to children 6- 35 months of age, for intramuscular use		WAIVED

	90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use		WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		WAIVED
	90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		WAIVED
	90672	Influenza virus vaccine, live, quadrivalent, for intranasal use		WAIVED

	90673	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use		WAIVED

	90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED

	90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use		WAIVED
	90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use		WAIVED
	G0008	Administration of influenza virus vaccine		WAIVED

Pneumococcal Vaccine	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	**B**	WAIVED
	90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use		WAIVED
	90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use		WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
Hepatitis B Vaccine	90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use	**A**	WAIVED

	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use		WAIVED
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED

	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	90759	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use		WAIVED
	G0010	Administration of Hepatitis B vaccine	**A**	WAIVED
Hepatitis C Virus Screening	G0472	Screening for Hepatitis C antibody	**B**	WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
HIV Screening	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple- step method, HIV-1 or HIV-2, screening	**A**	WAIVED
	G0433	Infectious agent antigen detection by enzyme- linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		WAIVED

	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2 , screening		WAIVED
Smoking Cessation for services furnished prior to October 1, 2016	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	**A**	WAIVED
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Smoking Cessation for services furnished on or after October 1, 2016	99406	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	**A**	WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	99407	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	***Not Rated**	WAIVED
	G0439	Annual wellness visit, including PPPS, subsequent visit		WAIVED

Intensive Behavioral	G0447	Face-to-Face Behavioral Counseling for Obesity, 15 minutes	**B**	WAIVED
Therapy for Obesity	G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s)		
Lung Cancer Screening	G0296	Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)	**B**	WAIVED
	G0297	Low dose CT scan (LDCT) for lung cancer screening		
COVID-19 Vaccine	See link	https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies		WAIVED

90.1 - HCPCS Coding for Diabetes Screening

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

The following HCPCS codes are to be billed for diabetes screening:

82947 - Glucose, quantitative, blood (except reagent strip)
82950 - post-glucose dose (includes glucose)
82951 - tolerance test (GTT), three specimens (includes glucose)
**83036 - Hemoglobin A1C level*

**Effective for claims with dates of service on or after January 1, 2024.*

90.2 - A/B MAC (B) Billing Requirements

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

Effective for dates of service January 1, 2005 and later, A/B MAC (B) shall recognize the above HCPCS codes for diabetes screening.

A/B MACs (B) shall pay for diabetes screening once every 12 months for a beneficiary that is not pre-diabetic. A/B MACs (B) shall pay for diabetes screening at a frequency of once every 6 months for a

beneficiary that meets the definition of pre-diabetes.

A claim that is submitted for diabetes screening by a physician or supplier for a beneficiary that does not meet the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82947, 82950 or 82951 with a diagnosis code of V77.1 (if ICD-9-CM is applicable) or (if ICD-10-CM is applicable) diagnosis code Z13.1, encounter for screening for diabetes mellitus reported in the header.

Effective for claims with dates of service on or after January 1, 2024, frequency limitations for diabetes screening are restricted 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 all eligible beneficiaries (two screenings every 12 months from the date of the initial screening). Medicare no longer distinguishes diabetes screening frequency limitations based on a prior diagnosis of pre-diabetes. The definition of pre-diabetes has been removed from diabetes screening regulatory text at 42 CFR 410.18.

A claim that is submitted for diabetes screening by a physician or supplier for a beneficiary shall be submitted in the following manner:

The line item shall contain 82947, 82950, 82951 or 83036 with an ICD-10-CM diagnosis code Z13.1, encounter for screening for diabetes mellitus reported in the header.

"Diabetes" means diabetes mellitus, a condition of abnormal glucose metabolism. See 42 CFR 410.18(a).

90.2.1 - Modifier Requirements for Pre-diabetes

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

A claim that is submitted for diabetes screening and the beneficiary meets the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82497, 82950 or 82951 with an ICD-9-CM diagnosis code of V77.1 reported (if ICD-9-CM is applicable) or, if ICD-10-CM is applicable, a diagnosis code of Z13.1in the header. In addition, modifier "TS" (follow-up service) shall be reported on the line item.

Effective for claims with dates of service on or after January 1, 2024, frequency limitations for diabetes screening are restricted 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 all eligible beneficiaries (two screenings every 12 months from the date of the initial screening). Medicare no longer distinguishes diabetes screening frequency limitations based on a prior diagnosis of pre-diabetes. The definition of pre-diabetes has been removed from diabetes screening regulatory text at 42 CFR 410.18.

90.3 - A/B MAC (A) Billing Requirements

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

Effective for dates of service January 1, 2005 and later, A/B MACs (A) shall recognize the above HCPCS codes for diabetes screening.

A/B MACs (A) shall pay for diabetes screening once every 12 months for a beneficiary that is not pre-diabetic. A/B MACs (A) shall pay for diabetes screening at a frequency of once every 6 months for a beneficiary that meets the definition of pre-diabetes.

A claim that is submitted for diabetes screening by a physician or supplier for a beneficiary that does not meet the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82947, 82950 or 82951 with an ICD-9-CM diagnosis code of V77.1 or, if ICD-10- CM is applicable, a diagnosis code of Z13.1.

Effective for claims with dates of service on or after January 1, 2024, frequency limitations for diabetes screening are restricted 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 all eligible beneficiaries (two screenings every 12 months from the date of the initial screening). Medicare no longer distinguishes diabetes screening frequency limitations based on a prior diagnosis of pre-diabetes. The definition of pre-diabetes has been removed from diabetes screening regulatory text at 42 CFR 410.18.

A claim that is submitted for diabetes screening by a physician or supplier for a beneficiary shall be submitted in the following manner:

The line item shall contain 82947, 82950, 82951 or 83036 with an ICD-10-CM diagnosis code Z13.1, encounter for screening for diabetes mellitus reported in the header.

"Diabetes" means diabetes mellitus, a condition of abnormal glucose metabolism. See 42 CFR 410.18(a).

90.3.1 - Modifier Requirements for Pre-diabetes

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

A claim that is submitted for diabetes screening and the beneficiary meets the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82497, 82950 or 82951 with a diagnosis code of V77.1 (if ICD-9-CM is applicable) or, if, ICD-10-CM is applicable, diagnosis code Z13.1. In addition, modifier "TS" (follow-up service) - shall be reported on the line item.

Effective for claims with dates of service on or after January 1, 2024, frequency limitations for diabetes screening are restricted 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 all eligible beneficiaries. Medicare no longer distinguishes diabetes screening frequency limitations based on a prior diagnosis of pre-diabetes. The definition of pre-diabetes has been removed from diabetes screening regulatory text at 42 CFR 410.18.

90.4 - Diagnosis Code Reporting

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

A claim that is submitted for diabetes screening shall include the diagnosis code V77.1 (if ICD-9-CM is applicable) or (if ICD-10-CM is applicable) diagnosis code Z13.1.

Effective for claims with dates of service on or after January 1, 2024, a claim that is submitted for diabetes screening shall include the ICD-10-CM diagnosis code Z13.1.

90.5 - Medicare Summary Notices

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

When denying claims for diabetes screening based upon a CWF reject for 82947, 82950 or 82951 reported with ICD-9-CM diagnosis code V77.1 or ICD-10-CM diagnosis code Z13.1, A/B MACs (A) and

(B) shall use MSN 18.4, “This service is being denied because it has not been 6 months since your last examination of this kind.” (See chapter 30 section 40.3.6.4(c) for additional information on ABN’s.)

Effective for claims with dates of service on or after January 1, 2024, when denying claims for diabetes screening A/B MACs (A) and (B) shall use the appropriate MSN that appropriately explains the denial of payment, such as MSN 9.4 – “The item or service was denied because information required to make payment was incorrect.”

90.6 - Remittance Advice Remark Codes

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

A/B MACs (A) and (B) shall use the appropriate remittance advice notice that appropriately explains the denial of payment*., such as N412 - “This service is allowed 2 times in a 12-month period.”*