CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 457 **Date: JANUARY 28, 2005**

CHANGE REQUEST 3677

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*: April 1, 2005
IMPLEMENTATION DATE: April 4, 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	18/Table of Contents
N	18/90/Diabetes Screening
N	18/90.1/HCPCS Coding for Diabetes Screening
N	18/90.2/Carrier Billing Requirements
N	18/90.2.1/Modifier Requirements for Pre-Diabetes
N	18/90.3/Fiscal Intermediary (FI) Billing Requirements
N	18/90.3.1/Modifier Requirements for Pre-Diabetes
N	18/90.4/Diagnosis Code Reporting
N	18/90.5/Medicare Summary Notices
N	18/90.6/Remittance Advice Remark Codes
N	18/90.7/Claims Adjustment Reason Codes

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

IV. ATTACHMENTS:

X	**Business Requirements**
X	**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: 457	Date: January 28, 2005	Change Request 3677

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: We issued regulations to conform to the MMA, and 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 individuals at risk for diabetes, including: (1) a fasting blood glucose test, and (2) a post-glucose challenge test. 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. To indicate that the purpose of the test(s) is for diabetes screening for a pre-diabetic, a screening diagnosis code V77.1 is required in the header diagnosis section of the claim and modifier "TS" – follow-up service.

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 two 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 noncovered.

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)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3677.1	CWF shall modify the existing edits changing the frequency from once every 6 to once every 12 months for dates of service January 1, 2005 and after for codes 82947, 82950 and 82951 billed with diagnosis code V77.1.								X	

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3677.2	CWF shall allow codes 82947, 82950 and 82951 billed with diagnosis code V77.1 and modifier "TS," no more than once every 6 months for dates of service January 1, 2005 and after.								X	
3677.3	Contractors shall deny claims for 82947, 82950 and 82951 billed with diagnosis code V77.1 and modifier "TS" upon receipt of a CWF reject that indicates the dates of services are more frequent than once every 6 months. When denying claims based upon a CWF reject for 82947, 82950 and 82951 contractors shall use MSN 18.4 "This service is being denied because it has not been 6 months since your last examination of this kind." Contractors shall use the appropriate claims adjustment reason code such as 119 "Benefit maximum for this time period or occurrence has been reached."	X		X		X				
3677.4	Effective April 1, 2005, CMS shall revise the HCPCS status modifier "TS" to indicate that special coverage instructions apply.									HCPCS Committee

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

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*: April 1, 2005 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Betty Shaw 410-786-4165 (coverage), Taneka Rivera 410-786-9502 (FI), Joan Proctor-Young 410-786-0949 (carrier) **Post-Implementation Contact(s): Your regional office**	**Medicare contractors shall implement these instructions within their current operating budgets.**

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

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev. 457, 01-28-05)

90 - Diabetes Screening

(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

90.1 - HCPCS Coding for Diabetes Screening

(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

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)

90.2 - Carrier Billing Requirements

(Rev.457,Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

Effective for dates of service January 1, 2005 and later, carriers shall recognize the above HCPCS codes for diabetes screening.

Carriers shall pay for diabetes screening once every 12 months for a beneficiary that is not pre-diabetic. Carriers 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 reported in the header.

90.2.1 - Modifier Requirements for Pre-diabetes

(Rev.457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

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 reported in the header. In addition, modifier "TS" (follow-up service) – shall be reported on the line item.

90.3 - Fiscal Intermediary (FI) Billing Requirements

(Rev.457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

Effective for dates of service January 1, 2005 and later, FIs shall recognize the above HCPCS codes for diabetes screening.

FIs shall pay for diabetes screening once every 12 months for a beneficiary that is not pre-diabetic. FIs 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.

90.3.1 - Modifier Requirements for Pre-diabetes

(Rev.457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

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. In addition, modifier "TS" (follow-up service) – shall be reported on the line item.

90.4 - Diagnosis Code Reporting

(Rev.457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

A claim that is submitted for diabetes screening shall include the diagnosis code V77.1.

90.5 - Medicare Summary Notices

(Rev.457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

When denying claims for diabetes screening based upon a CWF reject for 82947, 82950 or 82951 reported with diagnosis code V77.1, contractors 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.)

90.6 - Remittance Advice Remark Codes

(Rev.457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

Contractors shall use the appropriate remittance advice notice that appropriately explains the denial of payment.

90.7 - Claims Adjustment Reason Codes

(Rev.457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

Contractors shall use the appropriate claims adjustment reason code such as 119 "Benefit maximum for this time period or occurrence has been reached."