



Reminder – Medicare Provides Coverage of Diabetes Screening Tests – JA0821

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Key Words

SE0821, Payment, Diabetes, Screening, Test

Contractors Affected

All Medicare contractors who pay claims for Medicare-covered diabetes screening tests

Provider Types Affected

All Medicare fee-for-service physicians, qualified non physician practitioners (physician assistants, nurse practitioners, and clinical nurses), providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims for Medicare-covered diabetes screening tests



MLN Matters article SE0821 serves as a reminder that Medicare pays for diabetes screening tests. To ensure proper reimbursement for these screening tests the correct procedure and diagnosis codes and modifier (when appropriate) must be used when filing claims. **This article conveys no new policy information.**

When filing claims for diabetes screening tests the following Healthcare Common Procedure Coding System (HCPCS) codes/Current Procedural Terminology (CPT) codes and diagnosis codes must be used to ensure proper reimbursement:

HCPCS/CPT Codes and Descriptors

Provider Needs to Know...

- **82947** – Glucose; quantitative, blood (except reagent strip)
- **82950** – Glucose; post glucose dose (includes glucose)
- **82951** – Glucose; Tolerance Test (GTT), three specimens (includes glucose)

Diagnosis Code and Descriptor

- **V77.1 – No modifier** - To indicate that the purpose of the test(s) is for diabetes screening for a beneficiary **who does not meet the definition of pre-diabetes**, screening diagnosis code V77.1 is required in the header diagnosis section of the claim.
- **V77.1 – TS modifier** - To indicate that the purpose of the test is for diabetes screening for a beneficiary **who meets the definition of pre-diabetes**, screening diagnosis code V77.1 is required in the header diagnosis section of the claim **and** modifier “TS” (follow-up service) is to be reported on the line item.

IMPORTANT NOTE: The Centers for Medicare & Medicaid Services (CMS) monitors the use of its preventive and screening benefits. By correctly coding for diabetes screening and other benefits, providers can help CMS to more accurately track the use of these important services and identify opportunities for improvement. When submitting a claim for a diabetes screening test it is important to use diagnosis code V77.1 and the “TS” modifier on the claim as indicated above along with the correct HCPCS/CPT code (see codes above) so that the provider/supplier can be reimbursed correctly for a screening service and not for another type of diabetes testing service.

Definitions

- **Diabetes:** Diabetes mellitus, is defined as a condition of abnormal glucose metabolism diagnosed using the following criteria:
 - A fasting blood glucose 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.
- **Pre-diabetes:** A condition of abnormal glucose metabolism diagnosed using the following criteria:
 - A fasting glucose level of 100 to 125 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.

Background

Covered Tests

Medicare will pay for the following diabetes screening tests:

- A fasting blood glucose test, and
- A post-glucose challenge test not limited to:

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- An oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults), OR
 - A 2-hour post-glucose challenge test alone.

Note: Other diabetes screening tests for which the CMS has not specifically indicated national coverage continue to be non-covered.

Eligibility

Medicare beneficiaries who have any of the following risk factors for diabetes are eligible for this screening 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 tolerance.

OR

Medicare beneficiaries who have a risk factor consisting of *at least two* of the following characteristics are eligible for this screening benefit:

- Overweight (a body mass index greater than 25, but less than 30 kg/m²);
- A family history of diabetes;
- Age 65 years or older;
- A history of gestational diabetes mellitus, or of delivering a baby weighing greater than 9 pounds.

Note: No coverage is permitted under the screening benefit for beneficiaries previously diagnosed with diabetes since these individuals do not require screening.

Frequency

Medicare provides coverage for diabetes screening tests with the following frequency:

Beneficiaries diagnosed with pre-diabetes:

- Medicare provides coverage for a maximum of two diabetes screening tests per calendar year (but not less than 6 months apart) for beneficiaries diagnosed with pre-diabetes.

Beneficiaries previously tested but not diagnosed with pre-diabetes or who have never been tested:

- Medicare provides coverage for one diabetes screening test per year (i.e., at least 11 months have passed following the month in which the last Medicare-covered diabetes screening test was performed) for beneficiaries who were previously tested and who were not diagnosed with pre-diabetes, or who have never been tested.

Note: The Medicare beneficiary must be provided with a referral by a physician or qualified non-physician practitioner for the diabetes screening test(s). The diabetes screening service covered by Medicare is a stand-alone billable service separate from the initial preventive physical examination (also referred to as the Welcome to Medicare Physical Examination) and does not have to be obtained within the first six months of a beneficiary's Medicare Part B coverage.

Operational
Impact

N/A

Reference
Materials

The related MLN Matters article can be found at <http://www.cms.hhs.gov/MLNmattersArticles/downloads/se0821.pdf> on the CMS website.