

preventive physical preventive examination that is performed for an individual who is not an eligible beneficiary as described in this section.

[69 FR 66420, Nov. 15, 2004, as amended at 71 FR 69783, Dec. 1, 2006; 73 FR 69932, Nov. 19, 2008]

§ 410.17 Cardiovascular disease screening tests.

(a) *Definition.* For purposes of this subpart, the following definition apply:

Cardiovascular screening blood test means:

(1) A lipid panel consisting of a total cholesterol, HDL cholesterol, and triglyceride. The test is performed after a 12-hour fasting period.

(2) Other blood tests, previously recommended by the U.S. Preventive Services Task Force (USPSTF), as determined by the Secretary through a national coverage determination process.

(3) Other non-invasive tests, for indications that have a blood test recommended by the USPSTF, as determined by the Secretary through a national coverage determination process.

(b) *General conditions of coverage.* Medicare Part B covers cardiovascular disease screening tests when ordered by the physician who is treating the beneficiary (see § 410.32(a)) for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms of cardiovascular disease.

(c) *Limitation on coverage of cardiovascular screening tests.* Payment may be made for cardiovascular screening tests performed for an asymptomatic individual only if the individual has not had the screening tests paid for by Medicare during the preceding 59 months following the month in which the last cardiovascular screening tests were performed.

[69 FR 66421, Nov. 15, 2004]

§ 410.18 Diabetes screening tests.

(a) *Definitions.* For purposes of this section, the following definitions apply:

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.

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.

(b) *General conditions of coverage.* Medicare Part B covers diabetes screening tests after a referral from a physician or qualified nonphysician practitioner to an individual at risk for diabetes for the purpose of early detection of diabetes.

(c) *Types of tests covered.* The following tests are covered if all other conditions of this subpart are met:

(1) Fasting blood glucose test.

(2) Post-glucose challenges including, but not limited to, an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults, a 2-hour post glucose challenge test alone.

(3) Other tests as determined by the Secretary through a national coverage determination.

(d) *Amount of testing covered.* Medicare covers the following for individuals:

(1) Diagnosed with pre-diabetes, two screening tests per calendar year.

(2) Previously tested who were not diagnosed with pre-diabetes, or who were never tested before, one screening test per year.

(e) *Eligible risk factors.* Individuals with the following risk factors are eligible to receive the benefit:

(1) Hypertension.

(2) Dyslipidemia.

(3) Obesity, defined as a body mass index greater than or equal to 30 kg/m².

(4) Prior identification of impaired fasting glucose or glucose intolerance.

(5) Any two of the following characteristics:

(i) Overweight, defined as body mass index greater than 25, but less than 30 kg/m².

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- (ii) A family history of diabetes.
- (iii) 65 years of age or older.
- (iv) A history of gestational diabetes mellitus or delivery of a baby weighing more than 9 pounds.

[69 FR 66421, Nov. 15, 2004]

§ 410.19 Ultrasound screening for abdominal aortic aneurysms: Condition for and limitation on coverage.

(a) *Definitions:* As used in this section, the following definitions apply:

Eligible beneficiary means an individual who—

(1) Has received a referral for an ultrasound screening for an abdominal aortic aneurysm as a result of an initial preventive physical examination (as defined in section 1861(w)(1) of the Act);

(2) Has not been previously furnished an ultrasound screening for an abdominal aortic aneurysm under Medicare program; and

(3) Is included in at least one of the following risk categories:

(i) Has a family history of an abdominal aortic aneurysm.

(ii) Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime.

(iii) Is an individual who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding abdominal aortic aneurysms, as specified by the Secretary through a national coverage determination process.

Ultrasound screening for abdominal aortic aneurysms means the following services furnished to an asymptomatic individual for the early detection of an abdominal aortic aneurysm:

(1) A procedure using soundwaves (or other procedures using alternative technologies of commensurate accuracy and cost, as specified by the Secretary through a national coverage determination process) provided for the early detection of abdominal aortic aneurysms.

(2) Includes a physician's interpretation of the results of the procedure.

(b) *Conditions for coverage of an ultrasound screening for abdominal aortic aneurysms.* Medicare Part B pays for one ultrasound screening for an abdominal aortic aneurysm provided to eligi-

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ble beneficiaries, as described in this section, after a referral from a physician or a qualified nonphysician practitioner as defined in § 410.16(a), when the test is performed by a provider or supplier that is authorized to provide covered ultrasound diagnostic services.

(c) *Limitation on coverage of ultrasound screening for abdominal aortic aneurysms.* Payment may not be made for an ultrasound screening for an abdominal aortic aneurysm that is performed for an individual that does not meet the definition of “eligible beneficiary” specified in this section.

[71 FR 69783, Dec. 1, 2006]

§ 410.20 Physicians' services.

(a) *Included services.* Medicare Part B pays for physicians' services, including diagnosis, therapy, surgery, consultations, and home, office, and institutional calls.

(b) *By whom services must be furnished.* Medicare Part B pays for the services specified in paragraph (a) of this section if they are furnished by one of the following professionals who is legally authorized to practice by the State in which he or she performs the functions or actions, and who is acting within the scope of his or her license.

(1) A doctor of medicine or osteopathy, including an osteopathic practitioner recognized in section 1101(a)(7) of the Act.

(2) A doctor of dental surgery or dental medicine.

(3) A doctor of podiatric medicine.

(4) A doctor of optometry.

(5) A chiropractor who meets the qualifications specified in § 410.22

(c) *Limitations on services.* The Services specified in paragraph (a) of this section may be covered under Medicare Part B if they are furnished within the limitations specified in §§ 410.22 through 410.25.

(d) *Prior determination of medical necessity for physicians' services—(1) Definitions.* (i) A “Prior Determination of Medical Necessity” means an individual decision by a Medicare contractor, before a physician's service is furnished, as to whether or not the physician's service is covered consistent with the requirements of section 1862(a)(1)(A) of the Act relating to medical necessity.