

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

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meet the definition of “eligible beneficiary” specified in this section.

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§ 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.

(ii) An “eligible requester” includes the following:

(A) A participating physician (or a physician that accepts assignment), but only with respect to physicians’ services to be furnished to an individual who is entitled to receive benefits under this part and who has consented to the physician making the request under this section for those physicians’ services.

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(B) An individual entitled to benefits under this part, but only with respect to physicians’ services for which the individual receives, from a physician, an advance beneficiary notice under section 1879(a) of the Act.

(2) *General rule.* Each Medicare contractor will, through the procedures established in CMS manual instructions, allow requests for prior determinations of medical necessity from eligible requesters under its respective jurisdiction for those services identified by CMS (updated annually in conjunction with the update to the MPFS and posted on that specific Medicare contractor’s Web site by the Healthcare Common Procedure Coding System procedure code and code description). Only those services listed on that Medicare contractor’s Web site on the date the request for a prior determination is made are subject to prior determination. Each contractor’s list will consist of the following:

(i) The national list, provided by CMS, of the most expensive physicians’ services (as defined in section 1848(j)(3) of the Act) included in the MPFS which are performed at least 50 times annually.

(ii) The national list, provided by CMS, of plastic and dental surgeries that may be covered by Medicare and that have an amount of at least \$1,000 on the MPFS (not including the adjustment for location by the GPCI).

(3) *Services with local coverage determinations (LCDs) or national coverage determinations (NCDs).* In instances where an LCD or an NCD exists that has sufficiently specific reasonable and necessary criteria addressing the particular clinical indication for the procedure for which the prior determination is requested, the contractor will send a copy of the LCD or NCD to the requestor along with an explanation that the LCD or NCD serves as the prior determination and that no further determination will be made.

(4) *Identification of eligible services.* CMS will identify the number of services that are eligible for a prior determination through manual instructions consistent with the criteria established in the regulation.