

This document provides a summary of reimbursement questions related to the delivery of the Medicare DSMT benefit. The information provided in this Q & A is intended as guidance only and is not intended as legal advice. Please contact each payer to determine the specific coverage and reimbursement practices and policies.

BILLING FOR DSMES

Q1. Who can bill for DSMES?

A: To bill Medicare, the program must be accredited by ADCES or recognized by ADA and also be a Medicare Part B supplier and submit a claim for another reimbursable service before they can bill for DSMT. DSMES programs will identify a sponsor that is recognized as Medicare Part B Supplier with an approved NPI# - sponsors can be individuals or entities. Sponsors do not have to be a member of the DSMES team but will be part of the organization where DSMES is delivered.

Q2. Is there a difference when billing DSMT in different settings?

A: The following **ENTITIES** can sponsor a DSMES program for billing CMS:

Hospitals
Critical Access Hospitals
Medical Practice Groups
Federally Qualified Health Centers
Home Health Agency
Rural Health Clinic
Pharmacies
Durable Medical Equipment Companies

The following **INDIVIDUALS** can sponsor a DSMES program for billing CMS:

Registered Dietitians and Nutrition Professionals
Physicians (MDs, DOs)
Physician Assistants
Nurse Practitioners
Clinical Nurse Specialists
Clinical Psychologists
Licensed Clinical Social Workers

Q3. Do commercial payers require ADCES or ADA accreditation to bill for DSMES?

This will vary by payer so contact each individual plan to see if they require a DSMES program to be recognized by the ADCES or ADA and confirm if they are using the G-codes. Some payers may also require or suggest CPT codes 98960 – 98962, these codes do not require ADCES/ADA recognition. Some private payers do not require ADCES/ADA recognition to bill DSMT.

Q4. I am a CDCES with a Medicare provider number. Is it possible to bill DSMT services under my Medicare number?

A: RNs and CDCESs are not recognized as Medicare providers, so they are unable to bill under their own provider numbers. To bill Medicare for DSMT, you must have an accredited program through either ADCES or ADA. Billing for DSMT would then be done under the provider number that is the sponsor of the accredited program (i.e., RD, physician, advanced practitioner, or hospital).

Q5. Can nurses, diabetes community care coordinators, and others bill Medicare for services provided by an accredited DSMES program?

A: RNs and other team members are not recognized as Medicare providers, so they cannot bill for services under their own provider numbers. To bill Medicare for DSMT, you must have an accredited program through either ADCES or ADA. Billing for DSMT would then be done under the provider number that is the sponsor of the accredited program (i.e., RD, physician, advanced practitioner, or hospital). In many organizations who use electronic medical records systems, individual team members often complete required billing information that is then reviewed by a billing specialist and the claim submitted on the appropriate CMS billing form electronically.

Q6. Can pharmacists bill Medicare for services provided by an accredited DSMES program?

A: A pharmacist is one of several key team members in an ADCES accredited or ADA recognized DSMT program but are not eligible to obtain a Medicare Part B supplier number, and therefore cannot bill DSMT under their own NPI. The billing for DSMT would be done under the pharmacy's NPI number assigned to the DSMES program (on the accreditation certificate). Many pharmacies already bill services to Medicare either as a DME supplier or Part D provider, but the pharmacy must submit Form CMS-855B application to become a Part B supplier.

Q7. How does an eligible individual or entity apply to bill Medicare for Part B services?

A: They must enroll as a Medicare Part B provider even if they already completed a Form CMS-855S. Go to: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrollment/Med-Provider-Enroll-MLN9658742.html>

Q8. What is a rendering provider in a DSMES program?

A: The rendering provider is listed on Medicare billing forms as the person who provided services.

A “rendering provider” must be identified on the CMS 1500 Form:

If the DSMES team member who furnished DSMES is not a Medicare Part B supplier:

The NPI# of a team member who is a Medicare Part B supplier is listed as “rendering”: RDNs, NPs, PAs, and MDs are often Medicare Part B Suppliers

Q9. Can I offer a free class in the community or bill only participants who have medical coverage for DSMES? Can I offer free sessions at one of my locations where many of our participants are uninsured or underinsured?

A: Many programs offer an option for patients who are under or uninsured. They have a policy in place that allows them to verify the coverage/benefit and offer discounted or sliding scale rates based on need.

1. For Medicare, if a service is covered (i.e., DSMT) services should be billed to Medicare and not offered for free.
2. As far as the co-pay, you need to do “diligence” to collect
3. Programs can create a self-pay/uninsured policy where services are discounted (must be consistent in charges and discounts etc.)
4. If you offer a “community service” like at a community fair and there is no billing and no insurance information collected, that should be okay, again assuming all patients are treated the same.

This is the official issue described in the federal register: <https://oig.hhs.gov/reports-and-publications/federal-register-notices/factsheet-rule-beneficiary-inducements.pdf>

COVERAGE AND CODES

Q10. How many hours of DSMT does Medicare cover?

A: The number of hours of DSMT coverage depends on whether it is the initial DSMT benefit period or follow-up training. Patients are eligible for 10 hours of DSMT during the initial DSMT period which must be completed within 12 consecutive months following the first billed DSMT visit. If more than 10 hours of DSMT is provided in the initial benefit period, Medicare will deny the claim and either the DSMES team or the patient would be financially responsible. Question 13 below covers the ABN form that can be used to ensure patients are aware that they may be financially responsible.

FREQUENTLY ASKED QUESTIONS: DSMES AND DSMT REIMBURSEMENT



The initial DSMT benefit period starts on the first date that DSMT was billed and must be completed within 12 continuous months.

Follow-up training for subsequent years is available every calendar year either after the initial benefit period or starting in January of the following year:

For example...

If all 10 hours of initial DSMT are completed within a calendar year, then they are eligible for follow-up training in January of the next year with a referral. For example, start DSMES in January 2021 and complete all 10 hours by March 2021, they are eligible for follow up in January 2022 and again in January every year thereafter with referral.

If the 10 hours of initial DSMT cross over into the next calendar year, then they are eligible for follow-up DSMT on the 13th month after the initial DSMT began, and then in January every year after with referral. For example, if Initial DSMES starts in February 2021 and the 10 hours of DSMT are completed in February 2022 they are eligible for follow-up in March 2022, and again in January every year thereafter with referral.

Q11. Is there a limit to the number of hours that can be billed as DSMT in one day?

A: Medicare has set limits that only 3 hours of individual education of G0108 can be billed on the same day/same patient and 6 hours of group education under G0109.

Q12. Do we have to offer both individual and group visits in our DSMT program?

A: For the initial training benefit, Medicare is expecting that 9 hours will be offered as a group and one hour as an individual – so providers should offer both individual and group.

Q13. Where can I find an ABN form?

A: CMS.gov has the ABN form and instructions: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ABN-Tutorial/formCMSR131tutorial111915f.html>

DETERMINING PREVIOUS EDUCATION, USE OF BENEFIT

Q14. Is there a way to find out if a Medicare patient has previously received DSMT under Medicare? For example, if a patient has recently moved, how many hours of services in other states have they received?

A: Please see the following Medicare article for more information on how to verify benefits coverage for Medicare beneficiaries: <https://www.cms.gov/files/document/checking-medicare-eligibility.pdf>

FEES

Q15. What is the average reimbursement for DSMT?

A: The 2023 Medicare National Fee Schedule rates are: G0108 (per 30 minutes) \$54.90, G0109 (per 30 minutes/per patient) would pay \$15.59). Please note that these are the National Average rates. You can find state-specific fee schedules on the CMS website at <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>. Enter the CPT code(s) and your state or locality, and the state-specific Medicare fee should appear. Commercial plans may set their fees as a percentage of Medicare, i.e., 120%-150%.

Q16. Can DSMT be rounded up? For example, if 48 minutes of DSMT are provided, can we round up and bill two 30-minute units?

A: There is no specific guidance by CMS on rounding up or down for the HCPCS DSMT codes. However, it is recommended that billing for DSMT under HCPCS codes G0108 and G0109 be based on actual face-to-face time and that providers do not round up.

Q17. When can we start billing for DSMT? Is it retroactive?

A: Providers can not submit claims until they are accredited. Medicare Administrative Contractors may allow you to bill retroactively for 30 days within accreditation received. But verify with your local Medicare Contractor (MAC)

Gestational Diabetes

Q18. Are there codes we can bill for educating pregnant women with GDM that are separate from DSMT?

A: If billing for DSMT, the codes would be the same – G0108 and G0109. Verify with the commercial payers on specific coverage criteria.

INCIDENT-TO

Q19. Does a provider have to be present or sign my DSMT notes?

A: No, DSMT **is not** considered “incident-to,” so the provider does not need to be present or sign notes.

LEGISLATIVE MANDATES

Q20. Which states have legislative mandates for diabetes care and supplies?

A: <http://www.ncsl.org/research/health/diabetes-health-coverage-state-laws-and-programs.aspx>

(Note: Employer self-funded plans (ERISA plans) are exempt from state mandates.)

MEDICAID

Q21. How can I find out if Medicaid covers DSMT in my state?

A: Each state Medicaid program has a specific website for providers to understand payment, coverage, and coding. <https://lawatlas.org/datasets/diabetes-self-management-education-laws>

OFF-SITE LOCATIONS

Q22. Can I expand my independent DSMT accredited programs to off-site locations such as a physician's office?

A: Yes, you can provide services in an off-site location. However, you will need to notify the accrediting body (ADCES or ADA) of the expansion of the off-site location. For more information about adding locations for DEAP accredited programs go to: diabeteseducator.org/deap. You will also need to inform your Medicare Administrative Contractor (MAC) and other payers that you now provide services at an additional location. You should be aware of the Stark Law or other legal considerations such as inducements. <https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/>

PROVIDER NUMBERS AND BILLING PROVIDERS

Q23. Do DSMES team members working in hospital-based outpatient (HOPD) DSMES programs need to get individual National Provider Identification Numbers or can they use the hospital's NPI?

A: If the DSMT program uses the hospital provider number (also an NPI number) to claim DSMT services, individual team members would not need separate NPIs. If you are an RDN or an advanced practice RN (e.g., a Nurse Practitioner), you would need an NPI to claim DSMT services as an individual Medicare supplier.

Medicare deleted the long-standing multi-disciplinary team requirement for reimbursement. CMS instructed its contractors to recognize that DSMES may be furnished by a solo practitioner/individual RDN, RN, or pharmacist when those services are billed by, or on behalf of, the DSMES entity accredited as meeting the National Standards by the Association of Diabetes Care & Education Specialists or the American Diabetes Association. A reminder that an RN or Pharmacist will need to partner with a billing sponsor eligible to bill Medicare Part B for services to be reimbursed for DSMT.

SAME DAY SERVICES

Q24. Will Medicare allow payment for MNT and DSMT on the same day?

A: MNT and DSMT cannot be billed on the same day.

Can physician services be billed on the same day as DSMT?

A: The physician visit billed under an evaluation and management code (E/M) would need to meet medical necessity criteria and services provided must be above and beyond DSMT. If the office visit and DSMT are billed under the same NPI, most likely they will not be paid separately. However, if the office visit and the DSMT are billed under two different NPIs, if the office visit met medical necessity and provided services above and beyond DSMT, then both visits may be eligible for separate payment.

SETTINGS

Q25. Q: Can DSMT be provided in the inpatient setting?

A: DSMT/MNT would be included in the DRG payment rendered to a beneficiary during an inpatient hospital stay. Most commercial payers follow CMS on this payment policy but verify directly with your commercial payers.

FQHC

Q26. Q: Can Federally Qualified Health Clinics bill for DSMT and MNT services?

A: FQHCs with an accredited program can bill for DSMT or MNT services. However, only individual sessions qualify as separate encounters. DSMT and MNT services may be provided in a group setting, but do not meet the criteria for a separate qualifying encounter, and therefore, cannot be billed as an encounter.

FQHCs may bill for DSMT services when they are provided in a one-on-one face-to-face encounter and billed using the appropriate HCPCS and site of service revenue codes.

- To receive payment for DSMT services, the DSMT services must be billed on TOB 77X with HCPCS code G0108 and the appropriate site of service revenue code in the 052X revenue code series in addition to the medical visit codes G0466 (new patient) or G0467 (established patient). This payment can be in addition to payment for a mental health visit on the same date of service that the beneficiary received qualifying DSMT services but will not incur separate payment if the DSMES visit is on the same day as another medical visit.

RURAL HEALTH CENTERS RHC

Q27. Q: Can Rural Health Clinics bill for DSMT services?

A: RHC's do not receive a separate payment for DSMT . However, RHCs are permitted to apply for accreditation or recognition and report the cost of such services on their cost report for

inclusion in the computation of their all-inclusive payment rates. However, DSMT does not constitute an RHC visit and is not paid separately.

TELEHEALTH, PHONE VISITS

A: DSMT and MNT are on the list of reimbursable Medicare telehealth services. Like reimbursement requirements for in-person education, telehealth must be provided within an accredited or recognized program.

In addition to meeting the above DSMT specific criteria, Medicare requires that all the telehealth components as stated in the statute must be met for a provider to furnish telehealth services:

Q28. Who can be reimbursed for diabetes self-management training (DSMT) services via telehealth?

A: CMS has updated their guidance to clarify that accredited and recognized DSMT programs, eligible to bill Medicare Part B directly for DSMT services, may furnish and bill for DSMT services provided via telehealth through 12/31/2024. DSMT programs may offer and bill for DSMT telehealth services regardless of the provider type (RNs, pharmacists, registered dietitians, etc.) furnishing the service.

Source: [CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency](#)

Q29. Q3: Are both audio and video required for CMS telehealth and what is the definition?

A: When delivering DSMT via telehealth, you should use technology with audio and video capabilities to ensure two-way, real time, interactive communication. Only in cases when audio and video are not possible, CMS will allow DSMT to be furnished with audio only (phone). This change is indicated on the list of Medicare telehealth services and in a separate document addressing hospital outpatient services.

With audio only DSMT, ADCES recommends that DSMES Teams document the mode of delivery, the reason the service is delivered audio only and any other relevant information. DSMT delivered via an audio-only format follows the same billing/modifier rules as DSMT furnished via telehealth using two- way audio and video communication.

Q30. How do you bill for DSMES via telehealth services?

A: NPs, PAs, CSWs and RDNs can furnish and bill for DSMT via telehealth if they are listed with the accredited or recognized program (on DEAP Dashboard for accredited programs). Medicare telehealth services are generally billed as if the service had been furnished in-person. DSMT

would still be billed under the accredited or recognized program entity using G0108 for 1:1 and G0109 for group.

CMS is now asking providers to report the POS code that would have been reported had the services been provided in person. For example, you may use the POS 11 modifier to indicate a service that would have been provided in an office. CMS has also directed providers to report the 95 modifier for services reported via telehealth. You should now use the appropriate POS modifier and the 95 modifier.

FQHC's and RHC's and Hospital Outpatient Programs see Q26 and Q27.

POS codes: [CMS Place of Service Code Set](#)

Q31. I provide DSMES in a private physician's office; can I provide telehealth from my home?

A: CMS is allowing providers to furnish telehealth services from their home without reporting their home address on their Medicare enrollment. This means that you can continue to bill from your currently enrolled location.

Q32. How much does Medicare pay for telehealth services?

A: Medicare pays the same amount for telehealth services as it would if the service were furnished in person.

Q33. Can diabetes care and education specialists provide DSMT via telehealth in a federally qualified health center (FQHC) or rural health center (RHC)?

A: Any service that Medicare has approved to be furnished via telehealth can be provided by an FQHC or RHC through December 31, 2024.

Under normal circumstances, accredited/recognized DSMT programs in FQHCs are reimbursed for one-on-one DSMT visits using code G0108. Prior to the PHE, these services could not be furnished via telehealth by FQHC or RHC. CMS defines telehealth as real-time audio-video communication (see previous questions for more detailed definition). Here are some additional details:

- Services can be provided by any healthcare practitioner working for the RHC or the FQHC within their scope of practice.
- Practitioners can furnish telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC, and can furnish any telehealth service that is approved under the Physician Fee Schedule (PFS). (G0108, is on the PFS).

FREQUENTLY ASKED QUESTIONS: DSMES AND DSMT REIMBURSEMENT



- RHCs and FQHCs will use an RHC/FQHC specific G code (G2025) to identify services that were furnished via telehealth; RHC and FQHC claims with the new G code will be paid at the \$98.27 rate.

Reference: [Medicare Billing Medicare as a Safety Net.](#)