Diabetes Coding Table

Association of Diabetes Care & Education Specialists

This chart contains billing codes to maximize return on investment in diabetes care and education. Please consult with your billing and compliance teams before implementing billing codes as they are subject to change.

Code/Type		Who Can Bill/ Other Notes	Increments/Frequency/Limits
G0108	Diabetes outpatient self-management training services, individual.	ADCES Accredited or ADA Recognized ONLY and varies by provider type.	Per 30 minutes (do not round up). National average: $56.18
G0109	Diabetes outpatient self-management training services, group session (2 or more).	ADCES Accredited or ADA Recognized ONLY and varies by provider type.	Per 30 minutes (do not round up); FQHC's and RHC's excluded. National average: $15.70
G0108 or G0109 with POS 02 modifier for Medicare; 95 modifier is often used for private payers but may vary.	By reporting place of service (POS) 02 modifier with HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) or G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes), the distant site practitioner attests that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training when it is indicated during the year.	ADCES Accredited or ADA Recognized ONLY and billed under program NPI#. (same as in person visits)	Per 30 minutes (do not round up). Medicare telehealth services, including individual and group DSMT services furnished as a telehealth service, could only be furnished by a physician, PA, NP, CNS, CNM, clinical psychologist, clinical social worker, or registered dietitian or nutrition professional, as applicable. RNs, pharmacists and other instructors are excluded.
97802	MNT; initial assessment and intervention, individual, face-to-face with the patient.	RD/RDN ONLY	Each 15 minutes. National average: $37.69
97803	MNT; re-assessment and intervention, individual, face-to-face with the patient.	RD/RDN ONLY	Each 15 minutes. National average: $32.45
97804	MNT; group (2 or more individual(s)).	RD/RDN ONLY	Each 30 minutes. National average: $17.10
G0270	Medical nutrition therapy; reassessment and subsequent	RD/RDN ONLY	Each 15 minutes. National average: $32.45

Code/Type		Who Can Bill/ Other Notes	Increments/Frequency/Limits
	intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient.		
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals).	RD/RDN ONLY	Each 30 minutes. National average: $17.10
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation (when applicable).	cannot be reported in conjunction with CPT® codes 95249, 95250 and/or 95251.	Requiring a minimum of 30 minutes of time. National average: $56.88
95249	Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording.	For Medicare - An MA, RN, LPN, or CDE may perform the elements in CPT codes 95249/95250 if "incident to guidelines" are met, meaning they are providing the service directed by a physician or other qualified healthcare provider.	Sensor for a minimum of 72 hours; printout of recording; may not be reported more than once for the duration that the patient owns the data receiver. Obtaining a new sensor and/or transmitter without a change in the receiver does not warrant reporting 95249 subsequent times. National Average: $58.62
95250	Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided	For Medicare - An MA, RN, LPN, or CDE may perform the elements in CPT codes 95249/95250	Sensor for a minimum of 72 hours; once per month. National average: $157.37

Code/Type		Who Can Bill/ Other Notes	Increments/Frequency/Limits
	equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording.	if "incident to guidelines" are met, meaning they are providing the service directed by a physician or other qualified healthcare provider.	
95251	Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report.	MD, DO, NP, PA.	Once per month National average: $35.59
98960	Education and training for patient self-management by a qualified, nonphysician healthcare professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family); individual patient.	MEDICARE WILL NOT REIMBURSE: Other payers often do.	Each 30 minutes.
98961	Education and training for patient self-management by a qualified, nonphysician healthcare professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family); 2-4 patients.	MEDICARE WILL NOT REIMBURSE: Other payers often do.	Each 30 minutes.
98962	Education and training for patient self-management by a qualified, nonphysician healthcare professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family); 5-8 patients.	MEDICARE WILL NOT REIMBURSE: Other payers often do.	Each 30 minutes.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent	Physicians can report 99211, but it is intended to report services rendered by other individuals in the practice, such as a nurse or other staff member.	5 minutes. National average: $23.03

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	performing or supervising these services.	Unlike other office visit E/M codes, a 99211-office visit does not have any specific key-component documentation requirements.	
G0466	Federally qualified health center (FQHC) visit, new patient; a medically necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.	FQHC	One or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem.
G0467	Federally qualified health center (FQHC) visit, established patient; a medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an FQHC visit.	FQHC	One or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem.
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.	The CCM codes describing clinical staff activities (CPT 99487, 99489, and 99490) are assigned general supervision under the Medicare PFS. General supervision means when the service is not personally performed by the	At least 20 minutes; once per month. National average: $41.17

Code/Type		Who Can Bill/ Other Notes	Increments/Frequency/Limits
	• Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. • Comprehensive care plan established, implemented, revised, or monitored.	billing practitioner, it is performed under his or her overall direction and control although his or her physical presence is not required.	
99491	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient. • Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. • Comprehensive care plan established, implemented, revised, or monitored.	Physicians and the following non-physician practitioners may bill CCM services: • Certified Nurse Midwives Clinical Nurse Specialists • Nurse Practitioners • PAs	At least 30 minutes, once per month. National average: $82.35
99487	Complex chronic care management services, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.	The CCM codes describing clinical staff activities (CPT 99487, 99489, and 99490) are assigned general supervision under the Medicare PFS. General supervision means when the service is not personally performed by the billing practitioner, it is performed	60 minutes, once per month. National average: $91.77

Code/Type		Who Can Bill/ Other Notes	Increments/Frequency/Limits
	• Establishment or substantial revision of a comprehensive care plan. • Moderate or high complexity medical decision making • 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	under his or her overall direction and control although his or her physical presence is not required.	
99489	Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure). Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report 99489 in conjunction with 99487. Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.	Time spent directly by the billing practitioner or clinical staff counts toward the threshold clinical staff time required to be spent during a given month. CCM services that are not provided personally by the billing practitioner are provided by clinical staff under the direction of the billing practitioner on an "incident to" basis (as an integral part of services provided by the billing practitioner), subject to applicable state law, licensure, and scope of practice. The clinical staff are either employees or working under contract to the billing practitioner whom Medicare	Additional 30 minutes, once per month; Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report 99489 in conjunction with 99487. Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month. National Average: $43.97

Code/Type		Who Can Bill/ Other Notes	Increments/Frequency/Limits
		directly pays for CCM.	
99457	Remote physiologic monitoring treatment management services requiring interactive communication with the patient/caregiver during the month.	Clinical staff/physician/other qualified healthcare professional time	20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month. National Average: $50.94
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, initial 15 minutes, with assessment, and intervention if provided.	Pharmacist	Initial 15 minutes, new patient.
99606	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, initial 15 minutes, established patient.	Pharmacist	Initial 15 minutes, established patient.
99607	Medication therapy management services provided by a pharmacist, individual, face-to-face with patient, each additional 15 minutes (List separately in addition to code for the primary service).	Pharmacist	Each additional 15 minutes (Use 99607 in conjunction with 99605, 99606).

MDPP: Medicare Diabetes Prevention Program utilizes a number of codes that are further clarified at the following link: https://innovation.cms.gov/Files/x/mdpp-billingpayment-refguide.pdf

References

- Use Medicare's Physician Fee Schedule Look-up Tool to Search Medicare's database by CPT® code and Medicare Administrative Contractor (MAC).
- Contact your MAC for specific coverage and billing guidelines and requirements.
- Refer to the most recent edition of the CPT® code book for current CPT® code information.
- Medicare Reimbursement Guidelines for DSMT.
- AAFP Guide to 99211.
- AACE Guide to CGM Codes.