2022 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: $56.06
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: $15.92
G0108 or G0109 with POS 02 modifier for Medicare; 95modifier 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.

DSMT via Telehealth under the PHE *Currently PHE in effect until end of April 16, 2022. (We anticipate one more extension through July 16, 2022)	Providers bill the same G-codes when providing DSMT via telehealth Must still have accredited program to bill via telehealth	Under the PHE: RNs and Pharmacists can provide DSMT via telehealth Audio only is allowed if visual mode is not available Both hospital-based and office -based programs can provide DSMT via telehealth during the PHE	Medicare DSMT payment rates are the same if service provided via telehealth or in-person
97802	MNT; initial assessment and intervention, individual, face-to-face with the patient.	RD/RDN ONLY	Each 15 minutes. National average: $37.37
97803	MNT; re-assessment and intervention, individual, face-to- face with the patient.	RD/RDN ONLY	Each 15 minutes. National average: $32.53
97804	MNT; group (2 or more individual(s)).	RD/RDN ONLY	Each 30 minutes. National average: $17.30
G0270	Medical nutrition therapy; reassessment and subsequent	RD/RDN ONLY	Each 15 minutes. National average: $32.53

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: $17.30
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).	Physician or Qualified Healthcare Professional (MD/DO, NP, PA, APRN)	Requiring a minimum of 30 minutes of time. National average: $56.41
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. Billed by physician or QHP	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: $59.87
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 or as directed by payer. National average: $151.58

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. Billed by physician or QHP	
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 or as covered by payer National average: $35.30
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.	Varies by payer – verify coverage directly with payer	Each 30 minutes. National average: $29.42
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.	Varies by payer – verify coverage directly with payer	Each 30 minutes. National average: $13.84
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.	Varies by payer – verify coverage directly with payer	Each 30 minutes. National average: $10.38

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 performing or supervising these services.	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. Unlike other office visit E/M codes, a 99211-office visit does not have any specific key-component documentation requirements.	5 minutes. National average: $23.53

Code/Type		Who Can Bill/ Other Notes	Increments/Frequency/Limits
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. Paid under the FQHC assigned encounter rate.
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. Paid under the FQHC assigned encounter rate.
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: $64.02

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: • Clinical Nurse Specialists • Nurse Practitioners • PAs	At least 30 minutes, once per month. National average: $86.17
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: $134.27

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 directly pays for CCM.	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: $70.60

Code/Type		Who Can Bill/ Other Notes	Increments/Frequency/Limits
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	Physician or Qualified Healthcare Professional (MD/DO, NP, PA, APRN)	National Average: $19.03
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	Physician or Qualified Healthcare Professional (MD/DO, NP, PA, APRN)	Must have at least 16 days of data in the 30 day time period National Average: $55.71
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: $50.18
+99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes (add on code to 99457)	Clinical staff/physician/other qualified healthcare professional time	National Average: $40.84
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. National Average: N/A
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. National Average: N/A
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). National Average: N/A

98966:	Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.		During the PHE, non-physician practitioners who are eligible to bill Medicare directly, including registered dieticians and nutritional professionals, may bill for audio-only telephone assessment and management services.* This list does not include RNs or pharmacists. Physicians, nurse practitioners, and physician assistants should use CPT® codes 99441—99443. These codes should not be used for DSMT. National Payment: $13.15
98967	Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion		During the PHE, non-physician practitioners who are eligible to bill Medicare directly, including registered dieticians and nutritional professionals, may bill for audio-only telephone assessment and management services.* This list does not include RNs or pharmacists. Physicians, nurse practitioners, and physician assistants should use CPT® codes 99441—99443. These codes should not be used for DSMT. National Payment: $24.24
98968	Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of		During the PHE, non-physician practitioners who are eligible to bill Medicare directly, including registered dieticians and nutritional professionals, may bill for audio-only telephone assessment and management services.* This list does not include RNs or pharmacists. Physicians, nurse practitioners, and physician assistants should use CPT®

	medical discussion		codes 99441—99443. These codes should not be used for DSMT. National Payment: $34.26
98970	Qualified non-physician healthcare professional online digital evaluation and management, for an established patient, for up to seven days, cumulative during the 7 days; 5–10 minutes		These codes are designated for e-visits, specifically online assessment and management of a patient. These are not specifically designated for phone visits. The Medicare fact sheet states that RDNs, physical therapists, occupational therapists, speech language pathologists and clinical psychologists can provide the following e-visits and bill the following codes (RNs and pharmacists are not listed). National Payment: $11.17
G2062	Qualified non-physician healthcare professional online digital evaluation and management service, for an established patient, for up to seven days, cumulative during the 7 days; 11–20 minutes		National Payment: $20.76
G2063	Qualified non-physician qualified healthcare professional online digital evaluation and management service, for an established patient, for up to seven days, cumulative during the 7 days; 21 or more minutes		National Payment: $32.18

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.