ADCES® Association of Diabetes Care & Education Specialists

FREQUENTLY ASKED QUESTIONS:

DSMES and DSMT Reimbursement

This document provides a summary of reimbursement questions related to the delivery of diabetes self-management education and support (DSMES) services. The information provided in the 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.

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MEDICARE

*Note: DSMT refers to the Medicare benefit for DSMES.

Getting Ready To Bill

Q1: What criteria need to be in place to bill for DSMT?

1. **Accreditation/recognition by ADCES or ADA.**
   Medicare requires that the program must be accredited by ADCES or recognized by ADA.

2. **A program will need to identify the NPI number under which the DSMT services will be billed.**
   The NPI number needs to be an individual or entity that is recognized as a Medicare Part B provider. This is often referred to as the "billing sponsor."

   The following **ENTITIES** can sponsor a DSMT program:
   » Hospitals
   » Critical Access Hospitals
   » Medical Practice Groups
   » Federally Qualified Health Centers
   » Home Health Agencies
   » Rural Health Clinics
   » Pharmacies
   » Durable Medical Equipment Companies

   The following **INDIVIDUALS** can sponsor a DSMT program:
   » Registered Dietitians and Nutrition Professionals
   » Physicians (MDs, DOs)
   » Physician Assistants
   » Nurse Practitioners.
   » Clinical Nurse Specialists
   » Clinical Psychologists
   » Licensed Clinical Social Workers

   Please note that the name associated with the billing NPI number is what will need to be on the ADCES/ADA certificate.

3. **The Medicare Part B entity or individual must be billing for another reimbursable service before the program can bill for DSMT under that NPI number.**
   Reimbursable services could include anything billed under Medicare Part A, B, or D. Please note that billing as a Medicare Diabetes Prevention Program (MDPP) does not meet this requirement as it is a nationwide pilot under the Innovation Center and not a permanent Medicare Part B benefit.

4. **The billing provider must complete CMS-885B or 855I form and enroll as a Medicare Part B provider.**
   They must enroll as a Medicare Part B provider even if they have already completed a Form CMS-855S.
   Go to: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrolment/Med-Prov-Enroll-MLN9658742.html

5. **The ADCES/ADA certificate needs to be filed with the local Medicare Administrative Contractor (MAC).**
   Once a program receives their accreditation/recognition certificate, it must be filed with the local MAC; otherwise claims will be denied. Be sure that the name associated with the NPI number being used to bill is what is listed on the certificate. If there are any changes to the NPI number, the certificate must be updated and refiled with the MAC. When a program renews their accreditation with ADCES or ADA, the new certificate will need to be filed with the MAC.

   Use this link to identify your MAC: https://www.cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs/who-are-macs

DSMT Benefit

Q2: Does Medicare require any specific lab tests to confirm diabetes diagnosis eligibility for DSMT and MNT?

Medicare only requires that the beneficiary be diagnosed with diabetes before referring them to DSMT or MNT. As of January 1, 2024, Medicare has removed the list of specific diagnostic tests that were previously required. As such, programs are no longer required to confirm that a specific test was used by the referring provider to diagnose diabetes. If a program is concerned about what criteria were used for the diagnosis, they can contact the referring physician/qualified healthcare professional.

Q3: How many hours of DSMT does Medicare cover?

The number of hours of DSMT coverage depends on whether it is the initial DSMT benefit period or follow-up training. Medicare beneficiaries are eligible for 10 hours of DSMT during the initial DSMT period, which is defined as the 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 the beneficiary would be financially responsible. **Q5** below covers the ABN form that can be used to ensure patients are aware that they may be financially responsible.

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

Two hours of follow-up training are available every calendar year either after the initial benefit period ends or starting in January of the following year (see below for when each applies). As with overages on initial training, any additional hours of follow-up DSMT provided beyond the 2 covered would result in a denied claim by Medicare.

Examples of when beneficiaries are eligible for follow-up training:

- 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 2024 and complete all 10 hours by March 2024, they are eligible for follow up in January 2025 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 September 2024 and the 10 hours of DSMT are completed in June 2025 they are eligible for follow-up in October 2025, January 2026, and in January every year thereafter with referral.

Q4: Is there a way to find out if a Medicare beneficiary has previously received DSMT under Medicare?

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. The MAC portal generates a report that includes all claims submitted to Medicare across the country.

Q5: What is an Advanced Beneficiary Notice (ABN) form and where can I find one?

An ABN form is used to ensure Medicare beneficiaries are aware that they may be financially responsible for a service. An example of when this may occur would be if they exceeded the limit of hours covered by Medicare's DSMT benefit.

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

Q6: Do we have to offer both individual and group visits in our DSMT program?

Medicare designed the initial DSMT training benefit as a group service, with limited exceptions for when beneficiaries may receive individual care instead of group (see the exceptions listed in the CMS Manual). Medicare therefore expects that, for most beneficiaries, 9 hours of the initial 10 hours will be offered as a group and only 1 hour as an individual and expects programs to offer both individual and group to the extent possible. Per the CMS Manual, if individual training has been provided to a beneficiary and the Medicare Administrative Contractor determines that training should have been provided in a group, reimbursement could be down-coded from individual to group.

Please note that group requirements do not apply to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Please see the FQHC and RHC sections for further explanation.

Q7: What if a person is enrolled in a class but they are the only person that showed?

Medicare does not have any written guidance on this scenario. Please check with your compliance team and your local MAC.

DSMT Codes and Reimbursement

Q8: What are the billing codes for DSMT?

» G0108 (one-on-one)

» G0109 (group, 2–20 individuals)

These codes are billed in units of 30 minutes. For example, if a participant was seen in a group session for 2 hours, 4 units would be billed.

Q9: What is the average reimbursement rate for DSMT?

The 2026 Medicare National Fee Schedule rates are: G0108 (per 30 minutes/patient) pays $55.78, G0109 (per 30 minutes/per patient) pays $16.03. Please note that these are the national average rates and the actual rate paid to your program will likely be somewhat higher or lower. In addition, rates change each year. You can find locality-specific fee schedules on the CMS website at https://www.cms.gov/medicare/physician-fee-schedule/search. Enter the CPT code(s) and your locality, and the locality-specific Medicare fee will appear.

Q:10 Can minutes of DSMT be rounded up for billing purposes? For example, if 48 minutes of DSMT are provided, can we round up and bill two 30-minute units?

CMS states that DSMT "is furnished in increments of no less than one-half hour" per the regulations. There is no specific guidance by CMS indicating that it is acceptable to round up. DSMT billing should be based on actual face-to-face time.

Q11: Is there a limit to the number of hours that can be billed per beneficiary for DSMT in one day?

Medicare has set limits on how many hours can be billed per beneficiary per day:

G0108

» 4 hours for facilities (example: hospital outpatient department)

» 3 hours for practitioners

G0109

» 6 hours for both facilities and practitioners

Q12: When can we start billing for DSMT? Is it retroactive?

After accreditation is received and the certificate is filed with the Medicare Administrative Contractor (MAC), a program can begin to submit claims. The MAC may allow programs to submit claims for DSMT services retroactive to the date of accreditation.

Team and Professional Credentials

Q13: Do DSMES programs need to have a multi-disciplinary team?

While not yet reflected in the CMS manuals, 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 ADCES or ADA. Please see **Q15** for billing for a DSMT program with only RN(s) or pharmacist(s).

Q14: Does having the CDCES certification allow me to bill for Medicare as a provider for DSMT?

The CDCES certification itself does not confer the ability to bill Medicare. Please refer to **Q1** for a list of individuals that can sponsor a DSMT program for billing Medicare.

Q15: Can nurses, pharmacists, or diabetes community care coordinators (DCCCs) bill Medicare for services provided by an accredited DSMES program?

RNs, pharmacists, and DCCCs are not recognized as Medicare providers, so they cannot bill for services under their own provider numbers. To bill Medicare for DSMT, you must first have an accredited program through either ADCES or ADA. Billing for DSMT would then be done under the provider NPI number or the facility NPI number of the sponsor of the accredited program (i.e., RD, physician, advanced practitioner, hospital, or pharmacy). Please refer to **Q1** for a list of entities and individuals that can sponsor a DSMT program for billing CMS. Refer to **Q28–29** for more information about billing for DSMT services provided in a pharmacy setting.

Q16: If our program bills under the NPI of a provider who is not part of the DSMES team (e.g., a physician), does that provider have to be present when care is rendered or sign the DSMES notes?

No, DSMT is **not billed** "incident-to," so the provider does not need to be present or sign notes.

Q17: Who do I list as the rendering provider on the CMS 1500 form?

Even though the rendering provider on a CMS 1500 form is technically defined as the person who provided the service, CMS recognizes that some DSMES team members may not be Medicare Part B providers (e.g., nurses and pharmacists). CMS, therefore, allows DSMT programs to list the NPI number of someone else who is a Medicare Part B provider. The person listed as the rendering provider does not have to be on the DSMES team and they do not have to be on site when the service is provided. See **Q1** for the list of providers who are eligible to enroll as Medicare Part B providers.

Settings

OFF-SITE LOCATIONS

Q18: Can I expand my independent DSMT accredited programs to off-site locations?

Yes, you can provide services at an off-site location. However, you will need to notify the accrediting body (ADCES or ADA) of the expansion to the off-site location. You will also need to file any additional accreditation/recognition certificates with your local Medicare Administrative Contractor (MAC). If expanding sites, you should be aware of the Stark Law and other legal considerations such as inducements: https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

INPATIENT

Q19: Is DSMT reimbursed in the inpatient setting?

The Medicare DSMT benefit pays for services rendered in the outpatient setting only. DSMT provided in the inpatient setting would be included in the Medicare Severity Diagnosis Related Group (MS-DRG) payment which is an all-inclusive payment for services rendered to a beneficiary during an inpatient hospital stay.

HOSPITAL OUTPATIENT DEPARTMENT (HOPD)

Q20: Do DSMES team members working in DSMES programs based in HOPDs need to get individual National Provider Identifiers (NPI) or can they use the hospital's NPI?

If the DSMES program uses the hospital's provider number (also an NPI number) to bill for DSMT services, individual team members would not need separate NPIs. However, if the hospital wanted to bill DSMES under the RDN or qualified non-physician practitioner, they would need NPIs to bill for DSMES services as individual providers. The RDN or qualified non-physician practitioner would also need to enroll as a Medicare Part B provider and re-assign their benefits to the hospital if this has not already been done.

Q21: Will adding an additional DSMT site in an HOPD setting impact billing for DSMT services?

Additional sites can be added as long as they are fully owned and operated by the HOPD. It is strongly recommended that you discuss adding additional sites with your compliance and billing teams.

Q22: If my accredited/recognized program is in a hospital and my hospital acquires or merges with another hospital, can it be added as a branch site or multisite?

It may be possible. Each hospital has its own Tax ID number and, despite the merger, may continue to use separate Tax ID numbers. HOPDs can only add additional sites that are owned by the hospital, but if the additional hospital keeps its own Tax ID number, they may be viewed as separate entities. Therefore, it is strongly recommended that you discuss this with your compliance and billing teams.

Q23: When DSMT is provided in an HOPD setting, is it paid under the Physician Fee Schedule (PFS) or the Outpatient Prospective Payment System (OPPS)?

DSMT is always paid under the PFS. Additionally, DSMT is paid the same rate regardless of whether it is billed from a facility or not. Medicare does not pay a facility fee on top of the DSMT professional fee. The DSMT services will be billed on a UB04 form if provided in the HOPD setting but will ultimately get paid under the PFS.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Q24: Can FQHCs bill for DSMT services?

FQHCs with an accredited or recognized program can bill for DSMT services. However, only individual sessions qualify as separate encounters. DSMT services may be provided in a group setting, but group services do not meet the criteria for a separate qualifying encounter and therefore cannot be billed as an encounter. Group DSMT sessions can be included on the FQHC's cost report.

» To receive payment for individual 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).

» Payment for DSMT services on the same day as another medical visit depends on the FQHC's payment system. If being paid under the Medicare PPS (most common), DSMT does not qualify for a separate payment on the same day as a medical visit, but it can be paid on the same day as a mental health or dental visit. However, if being paid for under the All-Inclusive Rate system, both DSMT and a medical visit may qualify for separate payments.

Q25: Can DSMT be provided via telehealth in an FQHC?

Any service that Medicare has approved to be furnished via telehealth (which includes DSMT) can be provided by an FQHC through December 31, 2027.

Accredited/recognized DSMT programs in FQHCs are reimbursed for one-on-one DSMT visits using code G0108. Here are some additional details:

» Services can be provided by any healthcare practitioner working for 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 FQHC, and can furnish any telehealth service that is approved under the Physician Fee Schedule (which includes G0108).

» 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 $97.53 per encounter (for calendar year 2026).

» For dates of service on or after October 1, 2026, RHCs and FQHCs must bill the individual CPT or HCPCS codes that describe the telehealth service they provide instead of HCPCS code G2025.

Reference: https://telehealth.hhs.gov/providers/billing-and-reimbursement/billing-medicare-as-a-safety-net-provider

RURAL HEALTH CLINIC (RHC)

Q26: Can RHCs bill for DSMT services?

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 DSMES services on their cost report for inclusion in the computation of their all-inclusive payment rates. In addition, only individual sessions are allowable on the cost report.

Q27: Can DSMT be provided via telehealth in an RHC?

Any service that Medicare has approved to be furnished via telehealth (which includes DSMT) can be provided by an RHC through December 31, 2027.

Accredited/recognized DSMT programs in RHCs can add one-on-one DSMT visits to their cost report. Here are some additional details:

» Services can be provided by any healthcare practitioner working for the RHC 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 and can furnish any telehealth service that is approved under the Physician Fee Schedule (PFS) (which includes G0108).

» RHCs will use an RHC-specific G-code (G2025) to identify services that were furnished via telehealth; RHC claims with the new G code will be paid $97.53 per encounter (for calendar year 2026).

For dates of service on or after October 1, 2026, RHCs and FQHCs must bill the individual CPT or HCPCS codes that describe the telehealth service they provide instead of HCPCS code G2025.

Reference: https://telehealth.hhs.gov/providers/billing-and-reimbursement/billing-medicare-as-a-safety-net-provider

PHARMACY

Q28: Can pharmacists bill Medicare for services provided by an accredited DSMT program?

A pharmacist is one of several key team members in an ADCES accredited or ADA recognized DSMT program. But pharmacists are not recognized as billing providers within Medicare. If a pharmacist is providing DSMES services out of a pharmacy, billing for DSMT would be done under the NPI number assigned to the pharmacy's DSMES program (name on the accreditation certificate).

Q29: What steps does a pharmacy need to take to bill for DSMT services?

If the pharmacy is not already a Medicare Part B provider, the following steps need to be taken:

1. **Accreditation/recognition by ADCES or ADA.**
   Medicare requires that the program must be accredited by ADCES or recognized by ADA.
2. **The pharmacy must be billing for another reimbursable service before the program can bill for DSMT.**
   Reimbursable services could include anything billed under Medicare Part A, B, or D. Please note that billing as a Medicare Diabetes Prevention Program (MDPP) does not meet this requirement as it is a nationwide pilot under the Innovation Center and not a permanent Medicare Part B benefit.
3. **The pharmacy must complete CMS-885B or 855I form and enroll as a Medicare Part B provider.**
   The pharmacy must enroll as a Medicare Part B provider even if they have already completed a Form CMS-855S. Go to: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrolment/Med-Prov-Enroll-MLN9658742.html. The enrollment will generate another PTAN.
4. **The ADCES/ADA certificate needs to be filed with the local Medicare Administrative Contractor (MAC).**
   Once the pharmacy receives their accreditation/recognition certificate, it must be filed with the local MAC; otherwise, claims will be denied. Be sure that the name associated with the NPI number being used to bill is what is listed on the certificate. If there are any changes to the NPI number, the certificate must be updated and refiled with the MAC. When a program renews their accreditation with ADCES or ADA, the new certificate will need to be filed with the MAC.

   Use this link to identify your MAC: https://www.cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs/who-are-macs

   The Diabetes Self-Management Education and Support Medical Billing Playbook for Pharmacies is a helpful resource from the CDC. https://www.cdc.gov/diabetes-toolkit/media/pdfs/2024/05/DSMES-Pharmacy-Billing-Playbook-v5-FINAL.pdf

CRITICAL ACCESS HOSPITAL

Q30: How does a Critical Access Hospital bill and get paid for DSMT?

Medicare has established two methods of payment for critical access hospitals. In both methods, DSMT is paid under the PFS.

Option I: Standard Method

» Bill on CMS-1500 form or electronic equivalent
» POS 22
» G0109 (group) or G0108 (individual)

Option II: Optional Method (practitioners must reassign their billing rights to the CAH)

» Bill on UB04 form or electronic equivalent
» Type of Bill 851
» Revenue Code 0969 or 0982
» G0109 (group) or G0108 (individual)

DURABLE MEDICAL EQUIPMENT COMPANY (DME)

Q31: What steps does a DME company need to take to bill for DSMT services?

If the DME is not already a Medicare Part B provider, the following steps need to be taken:

1. **Accreditation/recognition by ADCES or ADA**
   Medicare requires that the program must be accredited by ADCES or recognized by ADA.
2. **The DME company will need to identify the NPI number under which the DSMT services will be billed.**
   Typically, the DME's NPI number will be used. Please note that the name associated with the billing NPI number is what will need to be on the ADCES/ADA certificate.
3. **The DME company must be billing for another reimbursable service before the program can bill for DSMT.**
   Reimbursable services could include anything billed under Medicare Part A, B, or D. Please note that billing as a Medicare Diabetes Prevention Program (MDPP) does not meet this requirement as it is a nationwide pilot under the Innovation Center and not a permanent Medicare Part B benefit.
4. **The DME company must complete CMS-885B or 855I form and enroll as a Medicare Part B provider**
   The DME company must enroll as a Medicare Part B provider even if they have already completed a Form CMS-855S. Go to: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrolment/Med-Prov-Enroll-MLN9658742.html.
5. **The ADCES/ADA certificate needs to be filed with the local Medicare Administrative Contractor (MAC).**
   Once the DME company receives their accreditation/recognition certificate, it must be filed with the local MAC; otherwise, claims will be denied. Be sure that the name associated with the NPI number being used to bill is what is listed on the certificate. If there are any changes to the NPI number, the certificate must be updated and refiled with the MAC. When a program renews their accreditation with ADCES or ADA, the new certificate will need to be filed with the MAC.

HOME HEALTH AGENCY

Q32: Can a Home Health Agency bill for DSMT?

Yes, however, DSMT is only payable when furnished outside of the Medicare Part A Home Health benefit. Therefore, DSMT cannot be part of the Home Health plan of care as this would be double billing.

Q33: What steps does a Home Health Agency need to take to bill for DSMT services?

If the Home Health Agency is not already a Medicare Part B provider, the following steps need to be taken:

1. **Accreditation/recognition by ADCES or ADA.**
   Medicare requires that the program must be accredited by ADCES or recognized by ADA.
2. **The Home Health Agency will need to identify the NPI number under which the DSMT services will be billed.**
   Typically, the Home Health Agency's NPI number will be used. Please note that the name associated with the billing NPI number is what will need to be on the ADCES/ADA certificate.
3. **The Home Health Agency must be billing for another reimbursable service before the program can bill for DSMT.**
   Reimbursable services could include anything billed under Medicare Part A, B, or D. Please note that billing as a Medicare Diabetes Prevention Program (MDPP) does not meet this requirement as it is a nationwide pilot under the Innovation Center and not a permanent Medicare Part B benefit.
4. **The Home Health Agency must complete CMS-885B or 855I form and enroll as a Medicare Part B provider.**
   The Home Health Agency must enroll as a Medicare Part B provider even if they have already completed a Form CMS-855S. Go to: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrolment/Med-Prov-Enroll-MLN9658742.html.

5. **The ADCES/ADA certificate needs to be filed with the local Medicare Administrative Contractor (MAC).**
   Once the Home Health Agency receives their accreditation/recognition certificate, it must be filed with the local MAC; otherwise, claims will be denied. Be sure that the name associated with the NPI number being used to bill is what is listed on the certificate. If there are any changes to the NPI number, the certificate must be updated and refiled with the MAC. When a program renews their accreditation with ADCES or ADA, the new certificate will need to be filed with the MAC.

TELEHEALTH

** **The information below reflects the extension of the Covid-era flexibilities in place through December 31, 2027.**

In order for services delivered via telehealth to be paid for by Medicare, four requirements must all be satisfied: 1) the service being provided is on the Medicare telehealth services list (see Q34), 2) the provider or entity billing for the service is eligible to bill Medicare for services delivered via telehealth (see Q35), 3) the provider of the service must be located somewhere that is eligible to serve as a "distant site" (see Q39) and 4) the patient is located, at the time of service, somewhere that is eligible to serve as an "originating site" (see Q36).

Q34: Is DSMT reimbursed if delivered via telehealth?

DSMT is on the list of reimbursable Medicare telehealth services. Like reimbursement requirements for in-person education, telehealth DSMT must be provided by an accredited or recognized program and follow all the benefit and coverage guidelines.

Q35: Who can be reimbursed for DSMT services when delivered via telehealth?

Prior to the Public Health Emergency in 2020, Medicare only allowed reimbursement for telehealth services delivered by a narrow set of provider types including physicians, RDs, NPs, and other Medicare billable providers. This restricted the ability of RNs and pharmacists from providing care via telehealth. However, as of January 1, 2024, Medicare now permanently pays for telehealth DSMT provided by any member of the accredited DSMT care team just as it does for in-person DSMT. See updated regulation: https://www.ecfr.gov/current/title-42/part-410/section-410.78#p-410.78(b)(2)(x)

Q36: Are there restrictions based on geography or other factors that dictate which Medicare beneficiaries can receive care via telehealth?

Prior to the Public Health Emergency in 2020, very few Medicare beneficiaries were eligible to receive care via telehealth, with the service primarily limited to beneficiaries in rural or medically underserved areas who traveled to certain types of health care facilities to receive telehealth from a provider at another location. However, these "originating site" restrictions have been temporarily lifted through December 31, 2027, allowing all Medicare beneficiaries to receive care via telehealth and allowing them to receive this care from their home or other non-facility location.

Q37: Are both audio and video required for CMS telehealth and what is the definition?

When delivering DSMT via telehealth, providers must have audio and video capabilities to ensure two-way, real-time, interactive communication. If the patient is located in their home (currently allowed through December 31, 2027), two-way, real-time audio-only communication will satisfy the requirement for an interactive telecommunications system under specific circumstances when a patient cannot use or does not consent to using video technology. Even if patients are receiving care from home, the provider must still offer audio and video to all patients.

For claims for audio-only services, providers must use modifier 93 to verify that all conditions have been met. Except for modifier 93, no additional documentation is required. However, ADCES recommends that DSMES teams document the mode of delivery, the reason the service is delivered audio-only, and any other relevant information.

Q38: How do you bill for DSMES services when delivered via telehealth?

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's sponsoring provider or supplier's NPI using G0108 for individual and G0109 for group. A place of service (POS) code and modifier are added to the claim to indicate where and how the services were performed.

HOPDs will use POS 19 or 22 and modifier 95 if both audio and video were utilized and 93 if only audio was utilized.

All other site settings will use POS 02 if the patient is not in their home and POS 10 if the patient is in their home. However, if only audio is utilized, then modifier 93 will be used. FQHCs and RHCs can use either modifier FQ or 93 to indicate audio only.

For dates of service on or after October 1, 2026, RHCs and FQHCs must bill the individual CPT of HCPCS codes that describe the telehealth service they provide instead of HCPCS code G2025.

POS codes: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

Q39: Can a provider be located in their home and provide DSMT via telehealth?

Yes, but if you have a private practice that is exclusively telehealth and your NPI is being used as the DSMT billing sponsor, you must report your home address as a practice location on your Medicare enrollment. "Home office for administrative/telehealth use only" location should be selected in order to suppress the details on your profile page on the CMS Care Compare Website.

Reference: https://www.cms.gov/files/document/understanding-telehealth-enrollment.pdf

Q40: How much does Medicare pay for services delivered via telehealth?

Medicare pays the same amount for a service delivered via telehealth as it would if the service were furnished in person.

Q41: Can DSMT be provided via telehealth by an FQHC or RHC?

Any service that Medicare has approved to be furnished via telehealth (which includes DSMT) can be provided by an FQHC or RHC through December 31, 2027.

Prior to the PHE, these services could not be furnished via telehealth by FQHCs or RHCs. 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 service via telehealth that is approved for that modality under the Physician Fee Schedule (which includes G0108).
- For dates of service through September 30, 2026, 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 this G code will be paid $97.53 per visit (for calendar year 2026).
- For dates of service on or after October 1, 2026, RHCs and FQHCs will stop using G2025. They will bill like they would an in-person service and add either the 95 (audio and visual) or 93 (audio only) modifier. They will continue to get paid $97.53 per visit rather than their encounter rate.

Reference: https://telehealth.hhs.gov/providers/billing-and-reimbursement/billing-medicare-as-a-safety-net-provider.

SAME-DAY SERVICES

Q42: Will Medicare allow payment for MNT and DSMT on the same day?

MNT and DSMT cannot be billed on the same day for a given beneficiary. Beneficiaries receiving both services will need to have them rendered on different days for the program to be paid separately for their services.

Q43: Can physician services be billed on the same day as DSMT?

If the office visit and DSMT are billed under the same NPI number the claims will most likely not be paid separately. However, both visits may be eligible for separate payment if the office visit and DSMT visit are billed under different NPI numbers and if the office visit meets medical necessity criteria and provides services above and beyond DSMT.

Q44: Will Medicare allow payment for group DSMT and individual DSMT on the same day for the same beneficiary?

Individual MACs may set their own policies, and it is advised to check with your local MAC before billing for both group and individual DSMT on the same day of service for a beneficiary.

MEDICARE ADVANTAGE

Q45: Are Medicare Advantage (MA) plans administered by Medicare?

No. MA plans are administered by Medicare-approved private health insurance companies. For more information, please see the Commercial section of this FAQ (Q49-54).

Q46: Do MA plans have the same DSMT benefits as Medicare Part B?

Yes, they have to offer the same Medicare Part benefits, including DSMT, but they have more flexibility in administering benefits.

Q47: Are the DSMT hours utilized under an MA plan tracked by Medicare?

No, they are not tracked by Medicare. If you need to know how many hours were utilized by the participant, you need to contact their MA plan.

Q48: Do MA plans cover DSMES delivered via telehealth?

MA plans have to cover the same telehealth services under Medicare Part B. However, since MA plans are administered through private health plans, they are subject to state telehealth laws. For state specific information on telehealth coverage, visit The Center for Connected Health Policy's website: https://www.cchpca.org/

COMMERCIAL/PRIVATE

Q49: Do commercial payers require ADCES or ADA accreditation/recognition to bill for DSMES?

This will vary by payer so contact each individual plan to see if they require a DSMES program to be accredited by ADCES or recognized by ADA. Some private payers do not require ADCES/ADA accreditation/recognition to bill DSMES.

Q50: What codes do commercial plans use for DSMES?

Commercial payers may use G0108 and G0109. However, some payers may require or suggest CPT codes 98960 – 98962.

Q51: Are reimbursement rates different for commercial payers versus Medicare?

Commercial plans may set their fees as a percentage of Medicare, e.g.,120%–150%, or may use alternative methods to determine payment rates. You can check your contract to determine your payment rate for each payer.

Q52: Does the billing sponsor of the DSMES services need to have a contract in place to get reimbursement from a commercial payer?

A contract may not be necessary if the participant's plan allows them to receive services from out-of-network providers.

Q53: Which states have legislative mandates for diabetes care and supplies for commercial plans?

See here for a repository of state diabetes coverage mandates: https://www.ncsl.org/health/accessing-diabetes-care-and-management

Note: Employer self-funded plans (ERISA plans), Medicare, TRICARE, the VA, and federal employee plans are exempt from state mandates, and state mandates may differ between Medicaid and state-regulated private plans.

Q54: Does commercial/private insurance cover DSMES services when provided via telehealth?

It will depend on each state's telehealth laws and possibly on individual plan policies as well. For state specific information on telehealth coverage, visit The Center for Connected Health Policy's website: https://www.cchpca.org/

MEDICAID

Q55: How can I find out if Medicaid covers DSMES in my state?

Each state Medicaid program has a specific website for providers to understand payment, coverage, and coding. The American Council on Aging website contains direct links to each states' Medicaid website: https://www.medicaidplanningassistance.org/state-medicaid-resources/

Q56: Which states have legislative mandates for diabetes care and supplies in Medicaid?

See here for a repository of state diabetes coverage mandates: http://www.ncsl.org/research/health/diabetes-health-coverage-state-laws-and-programs.aspx

Note: Employer self-funded plans (ERISA plans), Medicare, TRICARE, the VA, and federal employee plans are exempt from state mandates, and state mandates may differ between Medicaid and state-regulated private plans.

Q57: Does Medicaid cover DSMES services when provided via telehealth?

It will depend on each state's telehealth laws. For state specific information on telehealth coverage, visit the Center for Connected Health Policy's website: https://www.cchpca.org/

NO INSURANCE COVERAGE

Q58: Can I offer a free class in the community or bill only participants who have medical coverage for DSMES?

Many programs offer an option for people who are under or uninsured or people who are insured but do not have DSMES coverage or have exhausted their benefit. They have a policy in place that allows them to verify coverage and benefits and offer discounted or sliding scale rates based on need.

1. For Medicare, if a service is covered (e.g., DSMT), services should be billed to Medicare and not offered for free.
2. As far as the co-pay, you need to do "due 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 participants are treated the same.

See here for more information from the HHS Office of Inspector General: https://oig.hhs.gov/documents/compliance/836/factsheet-rule-beneficiary-inducements.pdf