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. 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.

Q2. Which entities or provider types are eligible to be a sponsor of a DSMES program when billing Medicare?

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 to 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. Does having the CDCES credential allow me to bill Medicare as a provider for DSMT?

A: The CDCES credential does not confer the ability to Medicare. Please refer to Q2 for a list of individuals that can sponsor a DSMT program for billing Medicare.

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 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, or hospital). Please refer to Q2 for a list of individuals that can sponsor a DSMES program for billing CMS.

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 pharmacists are not recognized as billing providers for DSMT. If the DSMES program is operating out of a pharmacy, the billing for DSMT would be done under the pharmacy's NPI number assigned to the DSMES program (on the accreditation certificate).

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 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

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.

However, all rendering providers listed on the CMS 1500 form must be Medicare Part B provider, so, if the DSMES team member who furnished DSMES is not a Medicare Part B provider, the NPI# of a team member who is a Medicare Part B provider is listed as "rendering provider." See Q2 above for the list of providers who are eligible to enroll as Medicare Part B providers.

Q9. Can I offer a free class in the community or bill only participants who have medical coverage for DMSES? 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 people 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 (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.

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. Does Medicare still require one of the three blood tests to confirm diabetes diagnosis for eligibility for DSMT and MNT?

A: As of January 1, 2024, Medicare has removed the list of specific diagnostic tests that were previously required for referring for DSMT and MNT. This means that 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 provider.

Q11. 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. 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 either the DSMES team or the beneficiary would be financially responsible. Question 14 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 billed and must be completed within 12 continuous months.

Two hours of follow-up training is available every calendar year either after the initial benefit period ends or starting in January of the following year. 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 2023 and complete all 10 hours by March 2023, they are eligible for follow up in January 2024 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 2022 and the 10 hours of DSMT are completed in June 2023 they are eligible for follow-up in October 2023, and again in January every year thereafter with referral.

Q12. Is there a limit to the number of hours that can be billed as DSMT in one day?

A: 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

Q13. Do we have to offer both individual and group visits in our DSMT program?

A: Medicare designed the initial DSMT training benefit as a group service, with limited exceptions for when beneficiaries may receive individual care instead of group. 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 will be down-coded from individual to group.

Q14. 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

Q15. Is there a way to find out if a Medicare beneficiary has previously received DSMT under Medicare? For example, if a beneficiary 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

Q16. What is the average reimbursement for DSMT?

A: The 2024 Medicare National Fee Schedule rates are: G0108 (per 30 minutes) $53.57, G0109 (per 30 minutes/per patient) would pay $15.39). Please note that these are the National Average rates and the actual rate paid to your program will likely be somewhat higher or lower. You can find state-specific fee schedules on the CMS website at https://www.cms.gov/medicare/physician-fee-schedule/search. 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, e.g., 120%-150%.

Q17. 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.

Q18. When can we start billing for DSMT? Is it retroactive?

A: Providers cannot submit claims until they are accredited. However, after accreditation is received, Medicare Administrative Contractors may allow programs to submit claims for DSMT services performed in the 30 days prior to the accreditation date on the certificate.

GESTATIONAL DIABETES

Q19. 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

Q20. 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 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

Q21. 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),Medicare, TRICARE, and federal employee plans are exempt from state mandates.)

MEDICAID

Q22. How can I find out if Medicaid covers DSMES in my state?

A: Each state Medicaid program has a specific website for providers to understand payment, coverage, and coding. In addition, this webpage contains a repository of coverage for DSMES as of 2017: https://lawatlas.org/datasets/diabetes-self-management-education-laws, but this may or may not reflect current law/regulations in your state.

OFF-SITE LOCATIONS

Q23. 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 to the off-site location. For more information about adding locations for DEAP accredited programs go to: Diabetes Education Accreditation Program (DEAP) (adces.org) . 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

Q24. Do DSMES team members working in DSMES programs based in hospital outpatient department (HOPDs) need to get individual National Provider Identification Numbers or can they use the hospital's NPI?

A: If the DSMES 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

Q25. Will Medicare allow payment for MNT and DSMT on the same day?

A: 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 in order for the program to bill fully for their services.

Q 26. Can physician services be billed on the same day as DSMT?

A: If the office visit and DSMT are billed under the same NPI number, most likely the claims will 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 met medical necessity and provided services above and beyond DSMT.

SETTINGS

Q27. Can DSMT be provided in the inpatient setting?

A: DSMT/MNT would be included in the DRG payment that covers a suite of services 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.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

Q28. Can Federally Qualified Health Centers bill for DSMT services?

A: 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.

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).
- 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 can be

paid on the same day as a mental health visit. However, if being paid under the All-Inclusive Rate system, both DSMT and a medical visit may qualify for separate payments.

****Refer to Q37 for information on telehealth in the FQHC setting.**

RURAL HEALTH CLINICS (RHC)

Q29. 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.

****Refer to Q37 for information on telehealth in the RHC setting.**

TELEHEALTH, PHONE VISITS

Q30. Is DSMT reimbursed if delivered via telehealth?

A: 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.

Q31. Who can be reimbursed for diabetes self-management training (DSMT) services when delivered via telehealth?

A: 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.

Q32: Are there restrictions based on geography or other factors that dictate which Medicare beneficiaries can receive care via telehealth?

A: 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. However, these "originating site" restrictions have been temporarily lifted through March 31, 2025. While we *anticipate* that telehealth access in Medicare will be further extended through 2025, as of the publication date of this FAQ, the end

date is still March 31, 2025. If you are accessing this document in spring 2025 or later, please check the ADCES website for updates as this sunset date may be outdated.

Q33. 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).

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.

Q34. How do you bill for DSMES services when delivered via telehealth?

A: 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.

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.

POS codes: CMS Place_of_Service_Code_Set

****FQHC's and RHC's see Q37.**

Q35. 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.

Q36. 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.

Q37. 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. If you are accessing this document in fall 2024 or later, please check the ADCES website for updates as we anticipate this sunset date will be pushed back.

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 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 telehealth service that is approved under the Physician Fee Schedule (PFS). (G0108, is on the PFS).
- 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 $ 96.87 rate.

Reference: Billing Medicare as a Safety Net