Diabetes Self-Management Training Billing for Rural Healthcare Professionals

American Diabetes Association®

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What is DSMES?

Diabetes self-management education and support (DSMES) is an evidence-based service that helps people with diabetes gain the knowledge, skills, and support needed for effective diabetes self-management and informed decision-making. DSMES services are typically provided by a multidisciplinary team that may include registered dietitian nutritionists (RDNs), registered nurses (RNs), pharmacists, certified diabetes care and education specialists (CDCESs), and other qualified healthcare professionals trained in diabetes care and education.

There is strong evidence for the positive impact of DSMES on diabetes knowledge, self-care behaviors, A1C, weight, quality of life, mortality risk, and healthcare costs. It is also associated with an increased use of primary care and preventive services and less frequent use of acute care and inpatient hospital services. Accordingly, the *Standards of Care in Diabetes—2026* recommends that healthcare professionals advise all people with diabetes to participate in developmentally and culturally appropriate DSMES, especially at diagnosis, annually, when not meeting treatment goals, when complicating factors develop, and/or when transitions in life and care occur.[1]

An accredited/recognized DSMES program may bill Medicare, private insurers, and some state Medicaid agencies for diabetes self-management training (DSMT) services. Although the acronym "DSMES" is used in clinical practice and the literature, "DSMT" is the term used to describe the Medicare benefit for diabetes self-management. Copays and coinsurance may apply depending on the individual's insurance coverage and benefits. Providing individuals and referring professionals with clear information about coverage, coinsurance responsibilities, and available financial assistance options may help reduce concerns about cost and decrease roadblocks to referral and participation.

This toolkit primarily focuses on Medicare reimbursement for DSMT services. Brief information regarding Medicaid reimbursement, other insurance considerations, and patient coinsurance obligations is also provided at the end of this document.

For additional information on coordination of benefits and determining which insurance payer is responsible for payment first, please refer to Medicare's publication, **Your Guide to Who Pays First**.

1 American Diabetes Association Professional Practice Committee for Diabetes*; 5. Facilitating Positive Health Behaviors and Well-being to Improve Health Outcomes: Standards of Care in Diabetes—2026. Diabetes Care 1 January 2026; 49 (Supplement_1): S89–S131. https://doi.org/10.2337/dc26-S005

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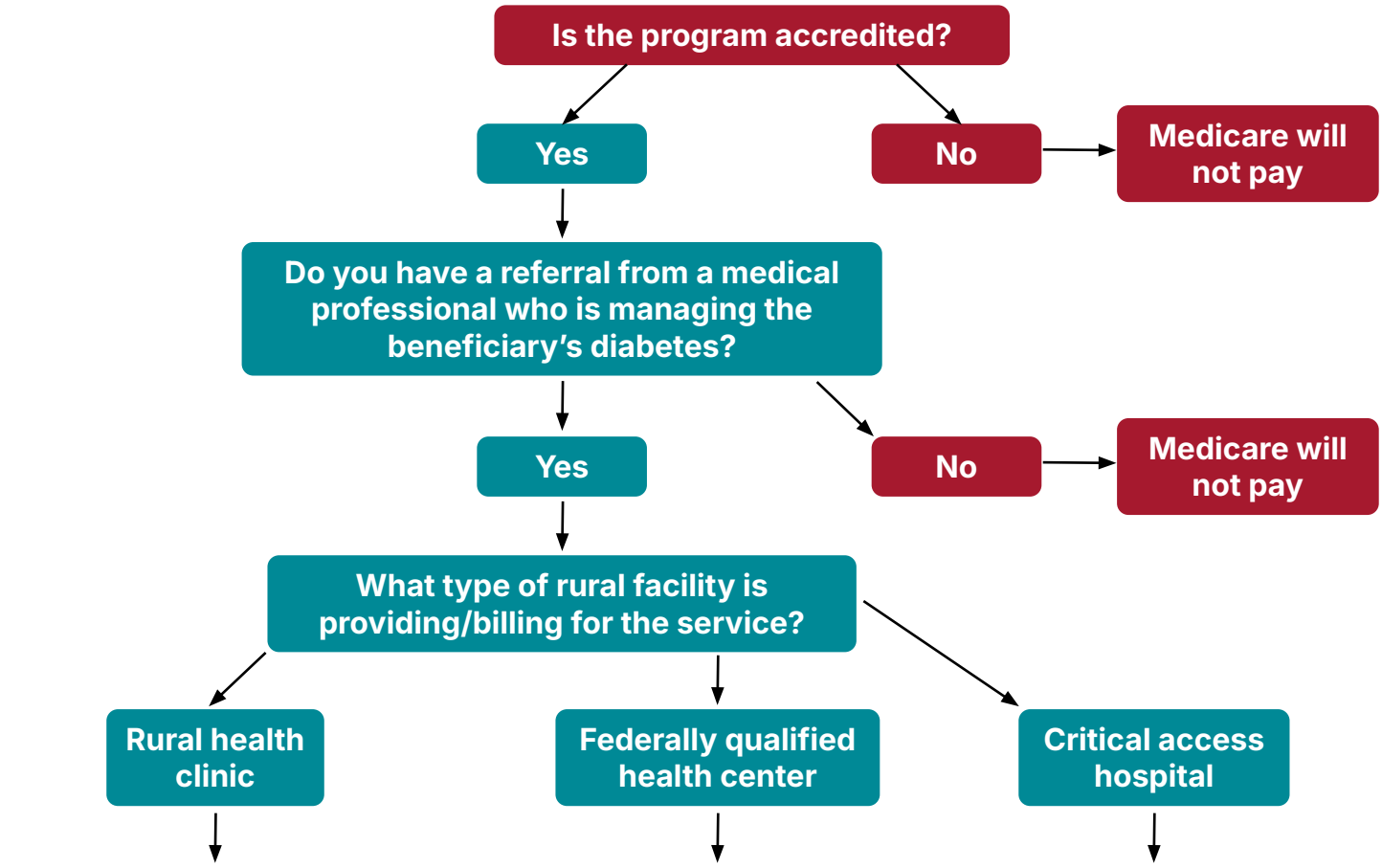
Bringing DSMES to Rural Areas and Underserved Populations

To support access to care for underserved populations, the United States healthcare system includes several different types of provider organizations, including federally qualified health centers (FQHCs), rural health clinics (RHCs), and critical access hospitals (CAHs). Services rendered at these facilities for Medicare beneficiaries are paid through alternate methodologies to the traditional Medicare physician fee schedule (MPFS) to help support their financial sustainability. Accredited/recognized DSMES programs providing DSMT services to Medicare beneficiaries in these organizations need to understand their unique billing and payment policies. This document provides an overview of how to bill for DSMT services and tips for maximizing revenues in each organization type.

In many accredited/recognized organizations, the DSMT services will be provided by a qualified member of the multidisciplinary care team and billed under a Medicare-approved billing provider. Under the Medicare program and consistent with the National Standards for DSMES, an RDN may be the sole provider of DSMT services within a Centers for Medicare & Medicaid Services (CMS)-accredited DSMT program if they are either a CDCES or have recent education and experiential preparation in diabetes management and education, as outlined in the **National Standards clarification guidance**.

Decision Tree for Billing DSMT for Rural Healthcare Professionals



- Not a billable visit (covered by the all-inclusive rate)
- Include on cost report for inclusion in computation of all-inclusive rate
- Provide during a medical visit and RHC receives payment for the medical visit at their all-inclusive rate (E/M office visit codes; G0108)
- Bill on UB04 or electronic equivalent
- Type of Bill 711
- Revenue code 0521

- Bill on UB04 form or electronic equivalent
- Type of bill: 771
- Revenue code: 0521
- G0467, G0108 (individual)
- Medicare does not pay for group DSMT, but can include in annual cost report

Option I: Standard Method
- Bill on CMS-1500 form or electronic equivalent
- POS 22
- G0109 (group) or G0108 (individual)
- Option II: Optional Method
- Bill on UB04 form or electronic equivalent
- Type of bill: 851
- Revenue code: 0969 or 0982
- G0109 (group) or G0108 (individual)

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Federally Qualified Health Centers

FQHCs are non-profit, patient-governed organizations that provide high-quality, comprehensive primary healthcare to medically underserved communities, serving all individuals [SP1.1]regardless of income or insurance status.

Medicare pays for services provided at an FQHC under a prospective payment system (PPS). Under this payment methodology, the FQHC is paid a flat, predetermined rate for each qualified visit ("encounter"), regardless of how many services are provided during that visit. Medicare sets a national base payment rate for FQHCs that is adjusted by geographic adjustment factors (GAF) to determine the local PPS rate and is updated annually. Services that fall outside the scope of PPS are reimbursed using fee-for-service payments. **The GAFs can be found on the CMS's website**.

A Medicare encounter is defined as:

A medically necessary, face-to-face (one-on-one) medical or mental health visit or qualified preventive health visit. This includes outpatient DSMT.

Important: Group classes are generally not reimbursed by Medicare in FQHCs.

Medicaid also pays FQHCs based on a PPS, with rates set under federal guidelines and often determined through annual cost reports. (See page 30 for more information on Medicaid coverage of DSMES services in West Virginia.)

Resource: Medicare Learning Network Booklet 006397: Federally Qualified Health Center.
https://www.cms.gov/files/document/mln006397-federally-qualified-health-center.pdf

FQHC: DSMT Workflow and Claim Example

Typical DSMT workflow:

1. Healthcare professional referral placed.
2. Patient scheduled for individual DSMT visit.
3. Visit documented by qualified educator.
4. Visit billed as FQHC medical encounter.

Common Codes

Code	Description
G0466	FQHC medical visit, new patient
G0467	FQHC medical visit, established patient
G0108	DSMT individual training

Example Claim (FQHC)

Scenario:	Patient attends 1-hour individual DSMT visit
Field	**Example**
Bill type	771
Revenue code	0521
HCPCS 1	G0467
HCPCS 2	G0108
Units	2

Payment: Medicare pays **80% of the PPS encounter rate**.

Example: National 2026 base payment rate

FQHC PPS rate	Medicare pays	Patient coinsurance
$207.72	$166.18	$41.54

Example: 2026 base payment rate with West Virginia GAF (0.937)

FQHC PPS rate	Medicare pays	Patient coinsurance
$194.63	$155.70	$38.93

Important notes:

- The payment from Medicare to the FQHC does NOT increase with more time units.
- A two-hour session pays the same as a 30-minute session if it is one encounter.

DSMT Billing: Practical Tips

Issue: Medicare **doesn't reimburse group DSMT** (billing code G0109) **in FQHCs**.

- The claim may process if other services are listed as part of the medical encounter, but no additional payment occurs beyond the encounter.

Solution: Schedule **individual DSMT sessions** and bill using G0108.

- Note: FQHCs may decide to offer group DSMT services as a healthcare professional efficiency measure and to leverage payment from other payers. G0109 services can be included on the FQHC cost report and may influence the following year's FQHC payment rate (particularly for Medicaid patients).

Issue: Medicare **doesn't reimburse two medical encounters on the same day** from a FQHC.

Solution: Schedule DSMT services on a **different day**.

- If possible, align DSMT visits with mental health or dental visits. This way you can bill for both a medical encounter and a mental health or dental encounter. This approach can also help reduce travel burden and improve care coordination for patients.
- Alternatively, schedule DSMT as a standalone encounter to support appropriate billing and dedicated time for diabetes education and support services.

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Issue:
Clinics **leave reimbursable hours unused**, delivering less than the full 10 hours available in the first year and/or less than the full hours available annually thereafter.

- Under Medicare rules from the CMS:

Benefit	Hours
Initial year	10 hours
Follow-up years	2 hours annually

- For Medicare, the "initial year" begins whenever the patient has their first DSMT billable session as a beneficiary. If Medicare has never paid for DSMT services, that beneficiary would still be eligible for the full 10 hours during a 12-month period, even if their diagnosis was years earlier.

Solution:
Schedule DSMT appointments for the **full number of hours** to which the Medicare beneficiary is entitled.

- Use automatic recalls to assist with bringing beneficiaries back for annual follow-up.
- **Verify benefits coverage** for Medicare beneficiaries

Issue:
Medicare **will not reimburse both DSMT and medical nutrition therapy (MNT)** services on the **same day**.

- Medicare covers both DSMT and MNT services, which provide complementary support for diabetes care.

Solution:
Schedule DSMT and MNT visits on different days to align with Medicare billing requirements.

- Schedule DSMT and MNT visits on separate days to maximize reimbursement opportunities, reduce missed revenue opportunities, and ensure Medicare beneficiaries receive the full benefit of both services.
- Coordinating services across separate visits can help programs optimize reimbursement while providing patients with comprehensive diabetes education and nutrition support throughout the year.

Potential Revenue Impact and Enhancement Strategies: FQHC

According to the **West Virginia Health Center program uniform data system report**, 16.4% of patients at the state's community health centers have diabetes, and 19.34% are Medicare beneficiaries. Assuming a population of 10,000 patients, we might estimate a FQHC cares for 317 patients with diabetes covered by Medicare.

Table A illustrates the revenue potential if 50% of those Medicare beneficiaries attended **one DSMT session** per year in West Virginia.

Scenario	Medicare Beneficiaries receiving DSMT	DSMT Individual Sessions	DSMT Session Length	Payment per Session	Total Revenue
DSMT session provided on same day as medical encounter	159	1	60 minutes (2 units)	$0	$0
30-minute DSMT session offered as standalone encounter OR same day as mental health or dental encounter	159	1	30 minutes (1 unit)	$194.63	$30,946
1-hour DSMT session offered as standalone encounter OR same day as mental health or dental encounter	159	1	60 minutes (2 units)	$194.63	$30,946
2-hour DSMT session offered as standalone encounter OR same day as mental health or dental encounter	159	1	120 minutes (4 units)	$194.63	$30,946

Notice that there is no revenue opportunity if a DSMT session is provided on the **same day as a medical encounter**.

There is, however, a **significant revenue opportunity** when the DSMT session is offered as a **standalone encounter** or on the **same day as a mental health or dental encounter**. The maximum revenue opportunity for an FQHC is the same whether one unit or four units of DSMT are provided that day. The program will need to determine how best to structure these sessions to achieve the optimal patient outcomes, operational efficiency, and revenue potential.

Table B illustrates the range of revenue opportunities if those same Medicare beneficiaries attend multiple sessions.

Scenario	Medicare Beneficiaries receiving DSMT	DSMT Individual Sessions	Payment per Session	Total Revenue
1 hour of DSMT	159	1 60-minute encounter	$194.63	$30,946
Annual follow-up benefit: 2 hours of DSMT sessions	159	2 60-minute encounter	$194.63	$61,892
Initial year benefit: 10 hours of DSMT	159	10 60-minute encounter	$194.63	$309,462

There is a wide range of potential Medicare revenue opportunities depending on how DSMT services are implemented. Nationally, less than 5% of Medicare beneficiaries utilize this DSMT benefit within the first year of diagnosis[2]. Across the state of West Virginia, 4,028 people had at least one DSMT encounter[3]. Meanwhile, West Virginia's community health centers alone reported caring for 57,673 patients with diabetes in 2024[4]. With many other insurances—including West Virginia Medicaid—also covering these services, it is possible to build a financially sustainable program.

To realize the potential and meet these unmet needs, effective integration of the education program into the FQHC's day-to-day clinical and operational activities is essential. A local implementation plan that engages referring healthcare professionals, scheduling, and billing is essential. Components of such a plan may include:

- Scheduling the DSMT service as a standalone medical encounter or on the same day as a mental health or dental encounter.
- Evaluating DSMT session content, DSMT provider schedules, space availability, and patient preferences to determine whether to offer 30- or 60-minute DSMT sessions. Since payment is made per encounter and not per number of units of DSMT (G0108) billed, revenue generation alone is not a factor. When making this decision, keep in mind that the patient will be responsible for coinsurance for each visit.
- Working with referring providers to refer all eligible Medicare beneficiaries with diabetes for DSMT services. Automated electronic health record (EHR) referrals can simplify this effort. If a patient received DSMT services prior to obtaining Medicare coverage, they are still eligible for DSMT services under their Medicare coverage.
- Implementing strategies to convert referrals into attending DSMT sessions.
- Using retention efforts to achieve 100% utilization of available DSMT benefit hours.

2 https://www.cdc.gov/diabetes-toolkit/php/about-dsmes/index.html
3 https://www.cdc.gov/diabetes-state-local/php/state-profiles/index.html#WV
4 https://data.hrsa.gov/topics/healthcenters/uds/overview/state/WV

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In addition to the above strategies, additional opportunities exist to enhance revenues associated with DSMT services:

- Provide both MNT and DSMT services to Medicare beneficiaries with diabetes. similar to DSMT, individual MNT services (CPT code 97802, 97803) can be billed as a medical encounter as a standalone service or when provided on the same day as a mental health or dental encounter. Medicare beneficiaries with diabetes are eligible for three hours of MNT services in the first year and two hours of MNT services annually thereafter (under certain situations with second referral, additional MNT hours are covered). MNT services can only be provided by an RDN who may or may not be a CDCES.
- Offer additional diabetes services covered by Medicare under the physician fee schedule (PFS). All of the following services can be provided by a CDCES or, in the case of chronic care management services, an RDN:
  - Continuous glucose monitoring training (CPT code 95249)
  - Insulin pump training (CPT code 95252)
  - Chronic care management services (CPT codes 99487, 99489, 99490)
- If the FQHC is owned by a hospital and the hospital has an accredited/recognized DSMT program, it may benefit the health system to have FQHC medical providers refer their patients with diabetes to the hospital's program to take advantage of access to group DSMT sessions. Hospitals can bill Medicare Part B for DSMT services with a payment rate of $16.03 per 30 minutes per person. A one-hour DSMT session with seven Medicare beneficiaries yields a payment of $224.42, slightly higher than the FQHC PPS base payment rate. This strategy may more efficiently utilize limited FQHC staff, such as RDNs.
- While West Virginia Medicaid reimburses for group DSMT sessions (G0109), those services are not billable in the FQHC setting. The organization may want to evaluate other operational and financial benefits of including Medicare and Medicaid beneficiaries with diabetes in those group education sessions before deciding whether to offer them. Even without separate reimbursement, the costs associated with providing those services can still be included in the FQHC's annual cost report. This may help influence the following year's Medicaid PPS rate or overall reimbursement calculations. Since Medicaid patients represent a significant portion of the FQHC population, group DSMT services may still provide long-term financial and operational value while also improving patient access to diabetes education and peer support opportunities.

Rural Health Clinics

An RHC is a public, non-profit, or for-profit healthcare facility that provides outpatient physician and non-physician services in rural and medically underserved areas. RHCs are required to use a team approach to healthcare delivery, using physicians working with nurse practitioners, physician assistants, and certified nurse midwives to provide services.

Medicare pays RHCs for qualified primary and preventive health services based on a bundled payment called the all-inclusive rate (AIR) for medically necessary primary health services and qualified preventive services provided one-on-one with the clinic patient[CG2.1]. DSMT is not considered a "qualified preventive service" for the purposes of defining a "visit" eligible for payment. Rather, the AIR covers these visits. RHCs submit an annual cost report to the CMS,

which is used to establish the per-visit payment limit for the RHC. At the end of each annual cost reporting period, the RHC submits a report to their Medicare Administrative Contractor (MAC) that includes their total allowable costs, total RHC service visits, and other required information. The MAC decides a final period rate by dividing allowable costs by the number of actual visits. Payments already made to the RHC are reconciled with the total payment due. The annual reconciliation may result in the RHC refunding money to the MAC or the MAC sending additional payment to the RHC.

Resource: Medicare Learning Network Booklet 006398: Information for Rural Health Clinics
cms.gov/files/document/mln006398-information-rural-health-clinics.pdf

RHC: DSMT Workflow and Claim Example

Typical DSMT workflow:

1. Patient scheduled with a **healthcare professional visit**.
2. Professional sees patient.
3. DSMT provided by an educator the **same day**. Under the Medicare program and per the National Standards, an RDN can be the sole provider of DSMT services if they are either a CDCES or has recent education and experiential preparation in education and diabetes management.
4. Entire service billed as **one RHC encounter**. DSMT alone **cannot generate payment**.

Common codes

Code	Description
99213/99214 (or RHC equivalent)	Provider visit
G0108	DSMT (informational only)

Example claim (RHC)

Scenario: Provider visit + 1-hour DSMT education

Field	Example
Bill type	71X
Revenue code	0521
HCPCS	99213
DSMT line	G0108 (non-payable)

Payment: Paid using **RHC AIR** rate

Example:

RHC AIR*	Medicare pays	Patient coinsurance
$165	$132	$33

**Based on 2026 national payment limit. To determine the AIR rate for a specific rural health clinic, check with your clinic's billing department.*

Important notes:

- DSMT does not increase payment beyond the encounter.
- Payment for G0108 will be denied.
- RHC can include G0108 services in annual cost report.
- Beyond payment under the AIR, DSMT services may improve outcomes on quality measures tied to value-based payments.

DSMT Billing: Practical Tips

Issue: In RHCs, **DSMT services do not qualify as a standalone billable encounter**.

Solution: Strategic scheduling can help ensure DSMT services are integrated into reimbursable patient visits while continuing to provide valuable diabetes education and support.

Recommended approach:

- Schedule DSMT on the **same day** as a qualifying healthcare professional visit whenever possible.
- Incorporate DSMT as part of the **AIR encounter,** allowing patients to receive both clinical care and diabetes self-management education in a coordinated visit.
- Track and capture DSMT services in the RHC's annual cost report, as these services may contribute to cost reporting calculations and potentially influence future AIR reimbursement rates.

Potential Revenue Impact and Enhancement Strategies: RHC

Since RHCs cannot bill DSMT as an independent RHC encounter, they should consider other strategies to maximize revenues from diabetes services, such as:

- Schedule DSMT services on the same day as a healthcare professional visit to recoup at least a portion of the cost of the DSMT service.
- Capture DSMT visits in the RHC's annual cost report to potentially increase the following year's AIR.
- Focus on quality metrics to leverage value-based payments from Medicare and other payers rather than revenues from AIR payments.
- If the RHC is owned by a hospital and the hospital has an accredited/recognized DSMT program, it may benefit the health system to have RHC medical professionals refer their patients with diabetes to the hospital's program to take advantage of access to payment for group DSMT sessions. Hospitals can bill Medicare Part B for group DSMT services with a payment rate of $16.03 per 30 minutes per person. A two-hour DSMT session with three Medicare beneficiaries yields a payment of $192.36, which is higher than the RHC 2026 national payment limit. This strategy may more efficiently utilize limited RHC staff, such as RDNs.
- Offer additional diabetes services covered by Medicare under the PFS. All of the following services can be provided by a CDCES or, in the case of chronic care management services, an RDN:
    - Continuous glucose monitoring training (CPT code 95249)
    - Insulin pump training (CPT code 95252)
    - Chronic care management services (CPT codes 99487, 99489, 99490)

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Critical Access Hospitals

CAH are rural hospitals that meet criteria set by the CMS to receive certain benefits, including more favorable reimbursement for Medicare services.

Medicare pays CAHs based on each hospital's reported costs and the share of those costs that are allocated to Medicare patients. Most inpatient and outpatient services provided to patients are paid at 101% of reasonable costs. Payments are not based on the type of service provided or the number of services provided. CAHs must submit a cost report to the CMS annually to determine their payment rate for the following year.

DSMT services are reimbursable outpatient visits at CAHs. Medicare has established two methods of payment for CAH outpatient services. CAHs are automatically paid using Option I: Standard Method. Under Option I, a CAH is paid 101% of reasonable costs. The practitioner bills their services directly to Medicare under the PFS and the payment goes directly to the clinician.

Alternatively, a CAH may select Option II: Optional Method. Under the Optional Method, CAHs are paid 115% of what would otherwise be paid under the Medicare Physician Fee Schedule (MPFS). The **PFS look-up tool** can be used to find MPFS payment rates for services provided in a specific locality. The practitioner reassigns their Medicare benefits to the CAH, and the CAH bills for services and receives the payments from the CMS. Each method separates payment for facility and professional services with different payment methods for each one. However, Medicare does not pay a facility fee on top of the professional fee for DSMT services provided in the hospital outpatient setting.

Resource: Medicare Learning Network Booklet 006400: Information for Critical Access Hospitals.
cms.gov/files/document/mln006400-information-critical-access-hospitals.pdf

CAH: DSMT Workflow and Claim Example

Typical DSMT workflow:

1. Healthcare professional orders DSMT.
2. Patient scheduled for **group or individual class**.
3. Certified educator (as defined under Medicare policies) provides DSMT.
4. Time tracked in **30-minute increments**.
5. Hospital bills Medicare Part B as an **outpatient service**.

Common codes

Code	Description
G0108	DSMES individual training (per 30 min)
G0109	DSMES group training (per 30 min)

Example claim

Scenario:	Patient attends 1-hour group DSMES
Field	**Example**
Bill type	851 (For Option II: Optional Method)
Place of Service	22 (For Option I: Standard Method)
Revenue code	0969 (other outpatient service) (For Option II: Optional Method)
HCPCS	G0109
Units	2
Charge	$120

Payment
Option I: Standard Method
Reimbursed under MPFS minus Part B deductible and coinsurance.

Example (based on national payment amount):

Professional Charge	MPFS Rate*	Patient Coinsurance	Medicare payment
$120	$32.06	$6.41	$25.65 (MPFS-coinsurance)

**Based on 2026 MPFS national payment amount*

Option II: Optional Method
Paid 115% of MPFS for professional services.

Example (based on national payment amount):

Professional Charge	MPFS Rate*	Patient Coinsurance	Medicare payment
$120	$32.06	$6.41	$30.46 (115% MPFS-coinsurance)

**Based on 2026 MPFS national payment amount*

Example if you are in West Virginia:

Professional Charge	MPFS Rate*	Patient Coinsurance	Medicare payment
$120	$30.42	$7.00	$27.98 (115% MPFS-coinsurance)

**Based on 2026 MPFS payment amount for WV*

DSMT Billing: Practical Tips

1. Billing DSMT services based on time.

Important billing consideration: In hospital outpatient settings, DSMT services billed with G0108 (individual DSMT) and G0109 (group DSMT) are time-based. **Accurate reporting of the number of units provided** helps ensure reimbursement reflects the full duration of the education service delivered. Proper unit billing can significantly impact program sustainability and support continued access to DSMT services.

Recommended approach:

- Bill G0108 and G0109 based on the total time spent providing DSMT services.
- Ensure documentation supports the length of the session and the number of units billed.
- Review billing processes regularly to confirm that all eligible units are being captured.

Examples

Session Length	Correct Billing
30 minutes	1 unit
60 minutes	2 units

Accurately billing for the full duration of DSMT services helps ensure appropriate reimbursement for the care provided and supports the long-term sustainability of diabetes education programs.

2. Leveraging both individual and group DSMT services.

Important service delivery consideration: Offering a combination of individual and group DSMT services can help programs optimize educator time, expand patient access, and support financial sustainability. Group DSMT sessions provide an opportunity to educate multiple participants simultaneously while fostering peer learning and shared problem-solving among individuals living with diabetes.

Recommended approach:

- Consider incorporating group DSMT sessions as a routine part of the program when appropriate for the patient population.
- Use individual DSMT sessions for the initial assessment, as well as for circumstances that require personalized instruction, such as insulin training or other situations permitted under Medicare guidelines (e.g., when a group class is not available within two months of the referral).
- Develop a scheduling strategy that balances individual and group education to maximize both patient benefit and program efficiency.

Example

Scenario	Approximate Revenue
1 educator + 1 patient	~$100
1 educator + 4 patients	~$128*

**Based on the MPFS national payment amount.*

Group DSMT sessions can be an effective way to extend educator capacity, increase access to services, and enhance program sustainability while continuing to meet the educational needs of people with diabetes.

3. Maximizing the Medicare annual DSMT benefit.
Under Medicare rules from the CMS, beneficiaries are eligible for:

Benefit Period	Hours Available
Initial year	10 hours (Medicare covers 1 hour individual and 9 hours group)
Follow-up years	2 hours annually (Medicare covers either individual or group)

Important utilization consideration: Medicare beneficiaries are entitled to a comprehensive DSMT benefit that supports ongoing diabetes self-management and education. Ensuring that beneficiaries receive the full number of available DSMT hours can improve access to diabetes education, reinforce self-management skills over time, and optimize reimbursement opportunities for the hospital.

Recommended approach:

- Schedule DSMT appointments to provide the full number of hours available to each Medicare beneficiary.
- Consider a combination of individual and group DSMT sessions (as dictated by insurance) to maximize patient engagement and efficient use of program resources
- Use automatic recall systems, reminders, and outreach processes to encourage Medicare beneficiaries to return for their annual follow-up DSMT benefit.
- Verify Medicare eligibility and benefits coverage annually to ensure beneficiaries can fully access their available DSMT services. Information on verifying Medicare eligibility is available through the **CMS Medicare eligibility verification guide**.

Fully utilizing the Medicare DSMT benefit helps beneficiaries receive ongoing education and support while strengthening program sustainability and reimbursement opportunities.

4. Coordinating DSMT and MNT services.

Important scheduling consideration: Medicare covers both DSMT and MNT, recognizing the important and complementary role each service plays in diabetes management. However, **Medicare does not reimburse both services when they are provided on the same day.** Strategic scheduling can help ensure Medicare beneficiaries receive the full benefit of both services while allowing programs to maximize available reimbursement opportunities.

Recommended approach:

- Schedule DSMT and MNT services on different days to align with Medicare billing requirements.
- Educate referral sources and scheduling staff about the importance of separating DSMT and MNT appointments to help Medicare beneficiaries fully utilize both covered benefits.

By scheduling DSMT and MNT on separate days, programs can optimize reimbursement, expand access to both services, and provide Medicare beneficiaries with a more comprehensive approach to diabetes self-management and nutrition care.

Potential Revenue Impact and Enhancement Strategies: CAH

The following revenue scenarios reveal several potential opportunities for CAHs to enhance revenues from DSMT services:

- Schedule regular group DSMT sessions to more efficiently utilize limited diabetes education staff. Remember an RDN/CDCES can be the sole provider of DSMT services.
- If the CAH owns any RHCs in the area, collaborate with the RHCs to refer patients to the CAH's DSMT program. The RHC will not receive payment from Medicare for DSMT services, providing the CAH the opportunity to increase its revenues for its DSMT program.
- Strive to achieve the minimum number of Medicare beneficiaries per group session needed to cover costs (and hopefully achieve a profit).
- Work with referring providers to refer all eligible Medicare beneficiaries with diabetes for DSMT services. Automated EHR referrals can simplify this effort. If a patient received DSMT services prior to obtaining Medicare coverage, they are still eligible for DSMT services under their Medicare coverage.
- Implement strategies to convert referrals into attendance at DSMT sessions.
- Use retention efforts to achieve 100% utilization of available DSMT benefit hours.

In addition to the above strategies, additional opportunities exist to enhance revenues associated with DSMT services:

- Provide both MNT and DSMT services to Medicare beneficiaries with diabetes. Remember DSMT and MNT services cannot be provided on the same day. Medicare beneficiaries with diabetes are eligible for three hours of MNT services in the first year and two hours of MNT services annually thereafter (under certain situations with second referral, additional MNT hours are covered).
- Offer additional diabetes services covered by Medicare under the PFS. The following services can be provided by a CDCES or, in the case of chronic care management services, an RDN:
    - Continuous glucose monitoring training (CPT code 95249)
    - Insulin pump training (CPT code 95252)
    - Chronic care management services (CPT codes 99487, 99489, 99490)

Impact of DSMT Program Structure on Potential Medicare Revenues

Scenario A: DSMT provided totally as individual services
Assumes delivery of DSMT through individual one-hour sessions, with billing for the maximum hours available under the Medicare benefit.

Annual Number of Medicare Beneficiaries Receiving DSMT	Number of DSMT Hours	Medicare Payment Rate/Hour	Total Annual Medicare Revenues (Excluding Coinsurance)	Revenue/Hour (Staff Time)
80	10 (full initial benefit)	$102.64	$82,112.00	$102.64
80	2 (full annual follow-up benefit)	$102.64	$16,422.40	$102.64

Scenario B: DSMT provided as 1 hour individual and 9 hours group
Assumes one-hour individual DSMT session, one-hour group sessions (eight patients/group), and billing maximum hours available under Medicare benefit.

Annual Number of Medicare Beneficiaries Receiving DSMT	Number of DSMT Hours	Delivery Method and Codes	Medicare Payment Rate/Hour	Total Annual Medicare Revenues (Excluding Coinsurance)	Revenue/Hour (Staff Time) *(See Appendix)
80	Full initial DSMT benefit (10 hours)	1 hour individual (G0108) + 9 hours group (G0109)	$102.64 $30.46	$30,142.40	$177.31 ** (see Appendix)
80	Full annual DSMT follow-up benefit (2 hours)	Group (G0109)	$30.46	$4,873.60	$243.68
80	Full annual DSMT follow-up benefit (2 hours)	Individual (G0108)	$102.64	$16,422.40	$102.64

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Impact of Recruitment and Retention Efforts by CAH on DSMT Revenue Potential

Efforts to increase Medicare beneficiary referrals to DSMT services, followed by engagement and retention efforts, can have a significant impact on program revenues. The following tables show the potential impact on Medicare revenues for group DSMT services offered at a CAH based on varying session lengths and three levels of patient engagement.

Table A: 60-Minute Group DSMT Sessions

Length of DSMT Session	Number of DSMT Group Sessions Attended per Year	Medicare Payment per Medicare Beneficiary per Session (Method I/ Method II)	Total Revenue per Medicare Beneficiary (Excluding Patient Coinsurance)	Annual Revenue Based on 35 Medicare Beneficiaries	Annual Revenue Based on 70 Medicare Beneficiaries	Annual Revenue Based on 100 Medicare Beneficiaries
60 minutes (2 units)	1	$30.46	$30.46	$1,006.10	$2,132.20	$3,046.00
60 minutes (2 units)	5	$30.46	$152.30	$5,330.50	$10,661.00	$15,230.00
60 minutes (2 units)	10 (maximum initial benefit)	$30.46	$304.60	$10,661	$21,322.00	$30,460.00
60 minutes (2 units)	2 (maximum annual benefit for follow-up training)	$30.46	$60.92	$2,132.20	$4,264.40	$6,092.00

Table B: 2-Hour Group DSMT Sessions

Length of DSMT Session	Number of DSMT Group Sessions Attended per Year	Medicare Payment per Medicare Beneficiary per Session (Method I/ Method II)	Total Revenue per Medicare Beneficiary (Excluding Patient Coinsurance)	Annual Revenue Based on 35 Medicare Beneficiaries	Annual Revenue Based on 70 Medicare Beneficiaries	Annual Revenue Based on 100 Medicare Beneficiaries
120 minutes (4 units)	1	$59.00	$59.00	$2,065.00	$4,130.00	$5,900.00
120 minutes (4 units)	5 (maximum initial benefit with no 1-hour individual session)	$59.00	$295.00	$10,325.00	$20, 650.00	$29,500.00
120 minutes (4 units)	1 (maximum annual benefit for follow-up training)	$59.00	$295.00	$2,065.00	$4,130.00	$5,900.00

Table C: 30-Minute Group DSMT Sessions

Length of DSMT Session	Number of DSMT Group Sessions Attended per Year	Medicare Payment per Medicare Beneficiary per Session (Method I/ Method II)	Total Revenue per Medicare Beneficiary (Excluding Patient Coinsurance)	Annual Revenue Based on 35 Medicare Beneficiaries	Annual Revenue Based on 70 Medicare Beneficiaries	Annual Revenue Based on 100 Medicare Beneficiaries
30 minutes (1 unit)	1	$14.74	$14.74	$515.90	$1,031.80	$1,474.00
30 minutes (1 unit)	5	$14.74	$73.70	$2,579.50	$5,159.00	$7,370.00
30 minutes (1 unit)	20 (maximum initial benefit with no 1-hour individual session)	$14.74	$294.80	$10,318	$20,636.00	$29,480.00
30 minutes (1 unit)	4 (maximum annual benefit for follow-up training)	$14.74	$58.96	$2,063.60	$4,127.20	$5,896.00

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Bottom line:

- In any scenario, the best financial outcomes come from fully utilizing the available DSMT benefit.
- For the initial benefit, revenue per Medicare beneficiary does not vary significantly by session length when the full initial benefit is utilized. Program design should be driven by patient factors (e.g., transportation, copays, schedules), healthcare professional schedules, and availability of space.
- For the follow-up benefit, revenue per Medicare beneficiary is best for a two-hour session. However, before implementing this program design, consider what best meets patient needs for education and support. Thirty-minute sessions yield the second-best revenue per Medicare beneficiary, although the other factors noted above should be taken into consideration.

Comparison of Coverage and Billing Requirements for DSMT in FQHCs, RHCs, and CAHs

Site of Service	Federally Qualified Health Center	Rural Health Clinic	Critical Access Hospital
Coverage for DSMT	Individual DSMT only	Not as a billable visit (covered by AIR)	Individual and group DSMT
Payment Methodology	PPS	AIR	Cost-based reimbursement: Option I: Standard Method or Option II: Optional Method
Reimbursement	Paid as medical encounter at the FQHC's specific encounter rate minus coinsurance. Medicare reimburses the FQHC 80% of the lesser of the FQHC PPS rate or the total of the charges. cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf nachc.org/wp-content/uploads/2023/07/Reimbursement-Tips_DSMT-MNT.pdf	Not paid separately for DSMT services but can be included on cost report for inclusion in computation of AIR. If no billable visit is rendered on the date of service, no claim is submitted. All line items billed with codes for DSMT services will be denied. cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf	**Option I**: Professional services reimbursed under MPFS minus Part B deductible and coinsurance. **Option II:** Professional services reimbursed at 115% of MPFS minus Part B deductible and coinsurance. Medicare does not pay a facility fee on top of the DSMT professional fee. cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf

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Site of Service	Federally Qualified Health Center	Rural Health Clinic	Critical Access Hospital
Claim Form	UB04 or electronic equivalent	UB-04 or electronic equivalent	Option I: CMS1500 or electronic equivalent for professional services (Part B MAC) Option II: UB04 or electronic equivalent for both facility and professional services (Part B MAC) **cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs/who-are-macs#MapsandLists** **cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf** **cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18.pdf**
Type of Bill Used on UB-04 forms to classify the kind of institutional claim being submitted (Field 04). **cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf**	771 (FQHC)	711 (RHC)	851 (CAH)

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Site of Service	Federally Qualified Health Center	Rural Health Clinic	Critical Access Hospital
Place of Service Code Used on CMS-1500 forms to identify where medical services are provided (Field 24B). **cms.gov/medicare/coding-billing/place-of-service-codes/code-sets**	50 (FQHC)	72 (RHC)	22 (on campus—outpatient hospital)
Revenue Codes Used on UB-04 forms to describe the department or service type (Field 42). **med.noridianmedicare.com/web/jea/topics/claim-submission/revenue-codes**	0521 (RHC/FQHC clinic visit)	0521 (RHC/FQHC clinic visit	0969 (other), 0982 (outpatient services)
HCPCS Codes	G0466 (FQHC visit, new patient) or G0467 (FQHC visit, established patient) PLUS G0108 – DSMT individual (per 30 min) Note: Since DSMT is paid under PPS, the number of units does not change payment received but must be included to track hours provided for eligibility purposes.	G0108 – DSMT individual (per 30 min)	G0108 – DSMT individual (per 30 min) G0109 – DSMT group (per 30 min)

Site of Service	Federally Qualified Health Center	Rural Health Clinic	Critical Access Hospital
Other Information	DSMT can be a standalone medical encounter (even on the same day as a mental health encounter) or included under a medical encounter provided on the same day. Group DSMT can be provided but cannot be billed as a medical encounter. These services can be included in the FQHC's annual cost report. Group services may be covered by Medicaid and/or commercial payers. DSMT cannot be provided on the same day as MNT cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf		Under Option II, practitioners must reassign their billing rights to the CAH. Generally same-day visits for another service (other than MNT) are allowed.
General References	cms.gov/files/document/mln006397-federally-qualified-health-center.pdf	cms.gov/files/document/mln006398-information-rural-health-clinics.pdf	cms.gov/files/document/mln006400-information-critical-access-hospitals.pdf

West Virginia Medicaid Coverage and Billing for DSMES Services

West Virginia's state Medicaid program provides coverage for diabetes management/education as a disease state management (DSM) program for people with diabetes under the **preventive services benefits**. Services must be coordinated by the patient's primary care practitioner, who either provides or refers the patient for diabetes DSM services.

For fee for service payment (**example: physician practice or independent RDN practice**), covered services must be provided by a certified diabetes educator (CDE). CDEs must be licensed practitioners and credentialed as a CDCES. RDNs are not eligible to enroll independently **as a provider** in West Virginia's Medicaid program. However, an RDN/CDCES can enroll solely to provide diabetes DSM services either as part of a facility or as an independent CDCES. They are eligible for reimbursement for **diabetes DSM services only**. An RDN who is not a CDCES can provide diabetes DSM services in a physician's practice, and the service would be billed under the physician's National Provider Identifier (NPI).

West Virginia Medicaid places the following limitations on coverage for diabetes DSM services:

- **Individual DSMT:** 8.5 hours/year
- **Group DSMT:** 8.5 hours/year
- **F/U visits/assessment with CDE:** 2 visits/year

The outpatient self-management training sessions can be a combination of individual and group sessions, not exceeding 8.5 hours per year.

Patients are eligible for both outpatient self-management training sessions and follow-up visits/assessments with a CDE on an annual basis. The number of total hours involving CDE education cannot exceed 10 hours per year per recipient.

Note: While Medicare defines "initial" as the 10 hours and "follow up" as the two hours in subsequent years (or that 13-month guideline), WV Medicaid appears to define "initial" and "follow up" as occurring within the same year. So, training sessions (8.5) + f/u reassessments (2) with CDE = 10 hours.

For more information, contact the West Virginia Department of Health, Bureau for Medical Services, Division of Policy Coordination and Operations, Office of Professional Services at 304-558-1700.

The following table summarizes coverage, billing and payment for DSMES/DSMT services delivered by various healthcare professionals under the state Medicaid program in West Virginia.

Facility Type	DSMES/DSMT Billing Approach	HCPCS Code(s)	Reimbursement Notes
FQHC	Included in PPS encounter methodology	FQHC medical encounter code (G0466/G0467) plus G0108 (individual DSMT)	Follows Medicare guidelines. Paid through FQHC prospective payment system rather than separate fee-for-service reimbursement. **Group DSMT is not separately reimbursable**. Facility-specific rates are established for each FQHC. Co-insurance applies. Since FQHC are paid under the PPS, an RDN or RN who is not a CDCES can provide the service the same way as under the Medicare program.
RHC	Covered service but not reimbursed as a separate RHC visit	G0108, G0109	Follows Medicare guidelines. **DSMT does not constitute a billable RHC encounter**.
CAH	Non-covered service	N/A	Education services or nutritional counseling are deemed **non-covered services** in the hospital outpatient setting.
Other Medicaid Providers (physician practices, ADA-recognized DSMES programs)	Fee-for-service billing	G0108 – Individual DSMT, per 30 minG0109 – Group DSMT, per 30 min	2026 West Virginia Medicaid fee schedule: G0108: $38.31 per 30 minutes G0109: $10.98 per 30 minutes **Actual WV Medicaid reimbursement may vary by provider type and managed care contract.**

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Appendix

Impact of DSMT Program Structure on Potential Medicare Revenues, Scenario B Table Page 21

How to Calculate Revenue per Staff Hour

Revenue per staff hour estimates the amount of Medicare reimbursement generated for each hour of educator time required to deliver DSMT services:

1. Calculate total annual Medicare revenue.
Total annual revenue = Number of beneficiaries × total DSMT reimbursement per beneficiary

2. Calculate total staff hours required to deliver DSMT.
For individual DSMT: Staff hours = Number of beneficiaries × individual DSMT hours

For group DSMT: Staff hours = (number of beneficiaries × group DSMT hours) ÷ average number of participants per group

Total staff hours = Individual staff hours + group staff hours

3. Calculate revenue per staff hour.
Revenue per staff hour = Total annual revenue ÷ total staff hours

Example: 80 Medicare beneficiaries receive 1 hour of individual DSMT and 9 hours of group DSMT.

- Total annual Medicare revenue = $30,142.40
- Individual staff hours = 80 × 1 = 80 hours
- Group staff hours = (80 × 9) ÷ 8 participants per group = 90 hours
- Total staff hours = 170 hours

Revenue per staff hour: $30,142.40 ÷ 170 = $177.31


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