



Physician Services Version

KEY CONCEPTS OUTLINE

Module 12: Medicare Coverage of Preventive Services

I. Preventive Evaluation and Management Services

A. Initial Preventive Physical Exam ("IPPE")

1. An IPPE is a specialized preventive physical examination designed to screen Medicare beneficiaries for a variety of diseases. The goals of the IPPE are health promotion and disease detection. IPPEs are sometimes referred to as "Welcome to Medicare" physical exams. <January 2015 CMS Flyer on "ABCs of IPPE">

2. Limitations on Coverage

a. Frequency Limit

- (i) Medicare allows only one IPPE for each beneficiary. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(C)>

b. Timing Limitation

- (i) An IPPE is only covered if the beneficiary receives the IPPE within twelve months after the effective date of his/her first Medicare Part B coverage. <42 CFR § 410.16(b), 410.16(a); Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(C)>

c. The Qualified Practitioner Limitations

- (i) Only IPPEs furnished by one of the following types of practitioners are covered:

(a) Physician (MD or DO),

(b) Physician Assistant,

(c) Nurse practitioner, or

(d) Clinical Nurse Specialist. <42 CFR § 410.16(b), 410.16(a); Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(B)>

d. Scope of Services Limitation

(i) To be covered, the IPPE must include: <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1>:

(a) Review of the beneficiary's medical and social history, including past medical and surgical history, current medications, family history, history of alcohol, tobacco and illicit drug use, diet, and physical activities;

(b) A review of the beneficiary's potential risk factors for depression or other mood disorders based on the use of standardized screening tests;

(c) A review of the beneficiary's functional ability and level of safety, including hearing impairment, activities of daily living, falls risk, and home safety;

(d) An examination which includes measurement of the beneficiary's height, weight, body mass index, blood pressure; visual acuity screen, and other factors based on the beneficiary's medical and social history and the clinical standards;

(e) End of life planning, upon consent of the individual, where verbal or written information may be obtained and used to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions; and

(f) Education, counseling, a written plan for obtaining appropriate preventive services, and referrals, if appropriate, based on the results of the IPPE evaluation. <42 CFR § 410.16(b), 410.16(a)>

3. Billing Issues

a. Specific HCPCS codes have been developed for billing for IPPEs and related services:

(i) G0402 – used to bill for the IPPE itself, including the face-to-face visit and related services. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(E)>

- (a) If a medically necessary E/M service is provided at the same visit as the IPPE, an E/M code with the -25 modifier may also be billed, indicating that the E/M service was a significant, separately identifiable service from the IPPE. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(G)>
- b. A referral for a screening electrocardiogram (EKG) may be made. When the screening EKG is performed as a result of the IPPE, specific HCPCS Level II codes are to be used. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(E)>
 - (i) G0403 – used to bill for a 12 lead EKG furnished in connection with an IPPE when the test (technical component) and interpretation (professional component) were both furnished by the billing entity.
 - (ii) G0404 – used to bill for a 12 lead EKG furnished in connection with an IPPE when only the test (technical component) was furnished by the billing entity.
 - (iii) G0405 – used to bill for a 12 lead EKG furnished in connection with an IPPE when only the interpretation (professional component) was furnished by the billing entity. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(E)>
- c. Prolonged Preventive Services <MLN Matters Article, MM10181>
 - (i) Effective January 1, 2018, Medicare established payment for prolonged preventive services when billed in addition to an applicable preventive service payable under the Medicare Physician Fee Schedule
 - (ii) Both deductible and coinsurance is waived
 - (iii) HCPCS Coding
 - (a) G0513 - Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)
 - (b) G0514 - Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in

addition to code G0513 for additional 30 minutes of preventive service

- (iv) Effective January 1, 2019, both prolonged preventive services, G0513 and G0514 are payable as telehealth services <83 Fed. Reg. 60031>

d. Screening for Abdominal Aortic Aneurysm (AAA)

- (i) Referral from an IPPE is no longer required. The 2014 Medicare Physician Fee Schedule Final Rule established a policy change. Effective January 27, 2014, Medicare beneficiaries eligible to receive ultrasound screening for abdominal aortic aneurysms (AAA screening) can be referred for this one-time benefit at any time.

- (a) Policy change removed the IPPE related referral.

- (ii) Provided on or after January 1, 2017

- (a) 76706 – used to bill for a screening ultrasound for abdominal aortic aneurysm

- (iii) Provided on or before December 31, 2016

- (a) G0389 – used to bill for an ultrasound screening for abdominal aortic aneurysm

- (iv) Payment may be made for a one-time ultrasound screening for AAA for beneficiaries who meet the following criteria:

- (a) receives a referral for such an ultrasound screening from the beneficiary's attending physician, physician assistant, nurse practitioner or clinical nurse specialist;

- (b) receives such ultrasound screening from a provider or supplier who is authorized to provide covered ultrasound diagnostic services;

- (c) has not been previously furnished such an ultrasound screening under the Medicare Program; and

- (d) is included in at least one of the following risk categories:

- (1) has a family history of abdominal aortic aneurysm;

- (2) is a man aged 65 to 75 who has smoked at least 100 cigarettes in his lifetime; or

(3) is a beneficiary who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determination process.

4. Coinsurance and Deductible Applicability

a. The Part B coinsurance and deductible are applied to the IPPE services as follows:

(i) IPPE (G0402) – Effective January 1, 2011, the coinsurance is waived. <MLN Matters SE1023>

(a) The deductible for the IPPE was waived starting January 1, 2009.

(ii) EKG codes (G0403, G0404, G0405) – The deductible and the coinsurance apply. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1(D)>

(iii) AAA screening (76706) – Starting January 1, 2011, both the deductible and coinsurance are waived. <One Time Notification Manual, Transmittal 864>

(a) Prior to January 1, 2011, G0389 was exempt only from the deductible. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A>

5. ABN/Limitation on Liability Issues

a. The ABN requirements applicable to IPPE services are as follows:

(i) IPPEs Furnished During the Twelve-Month Eligibility Period

(a) Beneficiary Receives More Than One IPPE

(1) No ABN is required in order to hold the beneficiary liable for additional IPPEs furnished during the twelve-month eligibility period. <Medicare Claims Processing Manual, Chapter 18 § 80.8>

(ii) IPPEs Furnished After the Twelve Month Eligibility Period

- (a) An ABN should be issued to hold beneficiaries liable when they are receiving any IPPE outside the twelve-month eligibility period. <Medicare Claims Processing Manual, Chapter 18 § 80.8>

B. Annual Wellness Visit (AWV)

1. The AWV is a preventive physical exam which includes personal prevention plan services (PPPS). <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A.2>
2. Limitations on Coverage
 - a. Frequency Limit
 - (i) Initial AWVs are a once in a lifetime benefit. Unlimited subsequent AWVs are allowed after sufficient time has passed. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A.2>
 - b. Timing Limitation
 - (i) Medicare will pay for an initial AWV if a beneficiary is more than 12 months past the effective date of his/her Medicare Part B coverage and has not received either an IPPE or an AWV within the preceding 12 months. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.C.2>
 - (a) Beneficiaries in their first 12 months of Part B coverage will only be eligible for an IPPE. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.C.2>
 - (ii) Subsequent AWVs will be allowed after more than 12 months have passed from the initial AWV or a previous subsequent AWV. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.C.2; Medicare Claims Processing Manual, Chapter 18 § 140.6>
 - c. The Qualified Practitioner Limitations
 - (i) AWVs provided by the following types of practitioners are covered:
 - (a) Physician (MD or DO),
 - (b) Physician Assistant,
 - (c) Nurse practitioner,
 - (d) Clinical Nurse Specialist

- (e) Other types of medical professionals include a health educator, registered dietitian, nutrition professional or other licensed practitioner or a team of such medical professionals who are working under the direct supervision of a physician. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.B>

d. Scope of Services Limitation

- (i) To be covered, the initial AWW must include: <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A.(2)>
 - (a) Establishment of, or update to, the individual's medical/family history,
 - (b) Measurement of height, weight, body mass index (BMI) or waist circumference, and blood pressure and other routine measurements as deemed appropriate,
 - (c) Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual;
 - (d) Detection of any cognitive impairment the individual may have,
 - (e) Review of an individual's potential risk factors for depression,
 - (f) Review of the individual's functional ability and level of safety,
 - (g) Establishment of a written screening schedule checklist for the individual for the next 5 to 10 years, as appropriate,
 - (h) Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits, and
 - (i) Provision of personalized health advice to the individual and referral, as appropriate, to health education or preventive counseling services. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A.(2)>
- (ii) To be covered, the subsequent AWW must include:
 - (a) Update to the individual's medical /family history,

- (b) Measurements of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical and family history,
- (c) Update to the list of the individual's current medical providers and suppliers that are regularly involved in providing medical care to the individual,
- (d) Detection of any cognitive impairment that the individual may have,
- (e) Update to the individual's written screening schedule as developed at the first AWW providing PPPS,
- (f) Update to the individual's list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, as that list was developed at the first AWW providing PPPS, and
- (g) Appropriate personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs.

3. Billing Issues

- a. Specific HCPCS codes were developed to describe AWW services effective January 1, 2011:
 - (i) G0438 – Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit
 - (ii) G0439 – Annual wellness visit, includes PPPS, subsequent visit
<Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.F.(2)>

C. COVID-19 Vaccine

1. Medicare coverage is provided for COVID-19 vaccines, additional doses, and booster doses.
 - a. Includes bivalent and updated vaccines.
2. Can be provided without physician's order or supervision.
3. Providers and practitioners can participate in the CDC COVID 19 vaccination program.
 - a. Administer the vaccine with no out-of-pocket cost to your patients for the vaccine or administration of the vaccine.
 - b. Vaccinate everyone, including the uninsured, regardless of coverage or network status.
 - c. Providers and Practitioners cannot:
 - (i) Balance bill for COVID-19 vaccinations;
 - (ii) Charge your patients for an office visit or other fee if COVID-19 vaccination is the only medical service given; or
 - (iii) Require additional medical or other services during the visit as a condition for getting a COVID-19 vaccination.
4. Appropriate HCPCS codes, payment allowances, and effective dates can be found at:

D. Monkey Pox Vaccine

1. Effective July 26, 2022, the Monkey Pox vaccine and administration are covered under Medicare.
 - a. The vaccine product is provided by the federal government.
 - (a) The no-charge product code will be addressed/adjusted during claims processing; therefore, product HCPCS codes are to be reported on the claim.
 - (b) Patient cost-sharing is only applicable to the administration codes.
 - b. Vaccine products are reported with CPT codes 90611 and 90622

c. Administration is reported with CPT codes 90471 or 90472.

II. Medicare Part D Vaccines

A. Medicare Part D plans provide coverage for all vaccines that are:

1. Commercially available
2. Reasonable and necessary to prevent illness
3. Not covered by Medicare Part B

B. Medicare Part D drug plans cover vaccine administration costs as part of each vaccine's negotiated price, including:

1. Dispensing fee (if applicable)
2. Sales tax (if applicable)
3. Vaccine administration fee
4. Vaccine ingredient cost

C. Beginning CY 2023, patients with Medicare drug plans will pay nothing out-of-pocket for adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).

D. The Inflation Reduction Act of 2022, Part 5, Section 11401 requires these vaccines to be free to patients and makes Part D vaccine cost-sharing consistent with coverage under Part B where the patient has no coinsurance or deductible.

III. Medicare Diabetes Prevention Program Expanded Model (MDPP)

Note: CMS extended the rule allowing all MDPP suppliers to use specific DMPP COVID-19 Public Health Emergency (PHE) flexibilities, through December 31, 2024.

A. Overview

1. A program consisting of evidence-based set of services aimed to help prevent the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes. < Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet>
2. The MDPP is a once in a lifetime benefit.
3. Clinical Goals of the MDPP Expanded Model
 - a. Attendance at core sessions and core maintenance sessions, or
 - b. Weight loss.
 - c. Long-term dietary change.
 - d. Adherence to long-term health behavior changes.

B. Supplier Enrollment <MDPP Provider Enrollment Fact Sheet; Fact Sheet Final Policies for the Medicare Diabetes Prevention Program Expanded Model in the Calendar Year 2018 Physician Fee Schedule Final Rule>

1. Supplier enrollment begins January 1, 2018, and will continue on a rolling basis.
2. To enroll as an MDPP supplier an entity must satisfy the following criteria and meet all other Medicare enrollment requirements:
 - a. At the time of enrollment has full CDC DPRP recognition.
 - b. Obtain and maintain an active and valid TIN and NPI at the organizational level.
 - c. Pass the application screening at a high categorical risk level § 424.518(c).
 - d. All coaches who will be furnishing MDPP services on the entity's behalf must obtain and maintain active and valid NPIs.

- e. Submit a roster of all coaches who will be furnishing MDPP services on the entity's behalf. The roster must include:
 - (i) Coaches' first and last names,
 - (ii) SSN, and
 - (iii) NPI.
3. Utilize the MDPP-specific application, CMS-20134
- C. Technology furnished to beneficiary by MDPP Supplier <42 CFR §424.210(b); 42 CFR §424.210(c)>
 1. Items, in aggregate, may not exceed \$1000.00 exceeding in retail value for any one beneficiary.
 2. The items must meet the following:
 - a. Be of the minimum technology required to meet/advance a clinical goal;
 - b. Must not be advertised or promoted as an incentive of the MDPP program; and
 - c. The cost of the technology cannot be shifted to another Federal program or the Medicare MDPP beneficiary.
 3. For technology items exceeding \$100.00 in retail value:
 - a. Must remain the property of the MDPP supplier;
 - b. Be retrieved from the MDPP beneficiary at the end of the engagement incentive period;
 - c. The MDPP supplier must document all retrieval attempts, including the ultimate date of retrieval.
 - (i) Documented diligent, good faith attempts to retrieve items of technology – considered to meet the requirements of retrieval.
- D. Effective April 1, 2018, MDPP Services were made available to eligible Medicare beneficiaries.
 1. Eligible beneficiaries are those who:
 - a. Are enrolled in Medicare Part B;

- b. Have a body mass index (BMI) of at least 25, or at least 23 if self-identified as Asian
 - c. Meet 1 of the following 3 blood test requirements within the 12 months of the first core session:
 - (i) A hemoglobin A1c test with a value between 5.7 and 6.4%, or
 - (ii) A fasting plasma glucose of 110-125 mg/dL, or
 - (iii) A 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test)
 - d. Have no previous diagnosis of type 1 or type 2 diabetes (other than gestational diabetes) and
 - e. Do not have end-stage renal disease (ESRD)
- E. Beginning January 1, 2022 – the program was transitioned to a 12-month program.
1. Structured sessions utilizing a “coach” and presenting a Center of Disease Control curriculum to provide training for changes in diet and physical activity while providing weight loss strategies and attendance goals.
 - a. Two components:
 - (i) Core Sessions
 - (a) MDPP suppliers must offer a minimum of 16 sessions, offered at least a week apart, during the first 6 months;
 - (b) Available to eligible beneficiaries regardless of weight loss and attendance; and
 - (c) MDPP suppliers must use a CDC-approved curriculum to guide sessions.
 - (ii) Core Maintenance Sessions
 - (a) Months 7-12;
 - (b) Sessions are available to eligible beneficiaries regardless of weight loss and attendance; and

- (c) MDPP suppliers must use a CDC-approved curriculum to guide sessions.
 - (d) Suppliers must offer a minimum of six-monthly sessions during the second six months..
- b. Given that MDPP is a once in a lifetime benefit, the program must be portable and make up sessions available.
 - (i) Beneficiaries are able to change MDPP suppliers.
 - (ii) Example: Dual cities, beneficiary relocation, and freedom of choice
- c. Make up Sessions must be available
 - (i) Can be in person or virtual
 - (a) In-person
 - (1) Must use same curriculum as session missed
 - (2) Maximum of one per week;
 - (3) Maximum of one per day of regularly scheduled sessions
 - (b) Virtual
 - (1) Same requirements as in-person make-up sessions;
 - (2) Only by beneficiary request;
 - (3) Compliant with Diabetes Prevention Recognition Program (DPRP) virtual standards;
 - (4) Maximum of 4 during the core services period, of which no more than 2 are core maintenance sessions;
 - (5) Maximum of 3 that are ongoing maintenance sessions; and
 - (6) Weight loss measurements taken cannot be used for payment or eligibility.
 - (7) All sessions, except the first session, may be provided as a virtual make up session.

(8) Modifier -VM should be appended to the appropriate HCPCS code to indicate the make-up session was provided via a virtual setting. <82 Federal Register, 53287>

- a. VM - Medicare diabetes prevention program (MDPP) virtual make-up session

2. MDPP Payment Structure and HCPCS Coding

- a. Core Sessions and Core Maintenance Sessions < 2024 Medicare FFS Billing and Payment Fact Sheet >

(i) Attendance – Fee-for-Service Payments

(1) HCPCS G9886 - Behavioral counseling for diabetes prevention, in-person, group, 60 minutes

- a. Beneficiary attended a core session in person, group, 60 minutes

- i. Medicare Reimbursement CY 2024- \$25.00

(2) HCPCS G9887 - Behavioral counseling for diabetes prevention, distance learning, 60 minutes

- a. The beneficiary attended a core session via distance learning, 60 minutes.

- i. Medicare Reimbursement CY 2024 - \$25.00

(ii) Performance Payments

(1) HCPCS G9880- The MDPP beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight in months 1-12 of the MDPP services period under the MDPP expanded model (EM). this is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by an in-person weight measurement at a core session or core maintenance session

- a. Billable once

- i. Medicare Reimbursement CY 2024 - \$145.00

(2) HCPCS G9881 - The MDPP beneficiary achieved at least 9% weight loss (WL) from his/her baseline weight in months 1-24

under the MDPP expanded model (EM). this is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by an in-person weight measurement at a core session, core maintenance session, or ongoing maintenance session

a. Billable once

i. Medicare Reimbursement CY 2024 - \$25.00

(3) HCPCS G9888 - Maintenance 5% WL from baseline weight in months 7-12

(iii) Bridge Payment

(1) Bridge payment: a one-time payment for the first Medicare diabetes prevention program (MDPP) core session, core maintenance session, or ongoing maintenance session furnished by an MDPP supplier to an MDPP beneficiary during months 1-24 of the MDPP expanded model (EM) who has previously received MDPP services from a different MDPP supplier under the MDPP expanded model. a supplier may only receive one bridge payment per MDPP beneficiary

a. Billable once per supplier

i. Medicare Reimbursement for CY 2024 - \$25.00

This content is from the eCFR and is authoritative but unofficial.

Title 42 — Public Health

Chapter IV — Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B — Medicare Program

Part 424 — Conditions for Medicare Payment

Subpart I — Requirements for Medicare Diabetes Prevention Program Suppliers and Beneficiary Engagement Incentives Under the Medicare Diabetes Prevention Program Expanded Model

Source: 82 FR 53364, Nov. 15, 2017, unless otherwise noted.

Authority: 42 U.S.C. 1302 and 1395hh.

Source: 53 FR 6634, Mar. 2, 1988, unless otherwise noted.

§ 424.205 Requirements for Medicare Diabetes Prevention Program suppliers.

- (a) **Definitions.** In addition to the definitions specified at § 410.79(b) and § 414.84(a) of this subchapter, the following definitions apply to this section:

Administrative location means a physical location associated with the MDPP supplier's operations where they are the primary operator in the space, from where coaches are dispatched or based, and where MDPP services may or may not be furnished.

Coach means an individual who furnishes MDPP services on behalf of an MDPP supplier as an employee, contractor, or volunteer.

Coach eligibility end date means the end date indicated by the MDPP supplier in submitting a change to the supplier's MDPP enrollment application in accordance with paragraph (d)(5) of this section that removed the coach's information, or the date the supplier itself was revoked from or withdrew its Medicare enrollment as an MDPP supplier.

Coach eligibility start date, means the start date indicated by the MDPP supplier when submitting the coach's information on the MDPP enrollment application.

Community setting means a location where the MDPP supplier furnishes MDPP services outside of their administrative locations. A community setting is a location open to the public not primarily associated with the supplier. Community settings may include, for example, church basements or multipurpose rooms in recreation centers.

Eligible coach means an individual who CMS has screened and has determined can provide MDPP services on behalf of an MDPP supplier in accordance with paragraph (e) of this section.

Ineligible coach means an individual whom CMS has screened and has determined cannot provide MDPP services on behalf of an MDPP supplier in accordance with paragraph (e) of this section.

MDPP interim preliminary recognition means a status that CMS has granted to an entity in accordance with paragraph (c) of this section.

- (b) **Conditions for MDPP supplier enrollment.** An entity may enroll as an MDPP supplier only if it satisfies the following requirements and all other applicable Medicare enrollment requirements:

- (1) Has either an MDPP preliminary recognition, as defined in paragraph (c)(1) of this section or a full CDC DPRP recognition.
- (2) Maintains an active and valid TIN and NPI at the organizational level.
- (3) Has passed screening requirements as follows:
 - (i) Upon initial enrollment, at a "high" categorical risk in accordance with § 424.518(c)(2); and
 - (ii) Upon revalidation, at a "moderate" categorical risk in accordance with § 424.518(b)(2).
- (4) Maintains, and submits to CMS through the CMS-approved enrollment application, a roster of all coaches who will be furnishing MDPP services on the entity's behalf that includes each coach's first and last names, middle initial (if applicable), date of birth, Social Security Number (SSN), active and valid NPI, coach eligibility start date, and coach eligibility end date (if applicable). This roster must be updated in accordance with paragraph (d)(5) of this section.
- (5) The Medicare provider enrollment application fee does not apply to all Medicare Diabetes Prevention Program (MDPP) suppliers that submit an enrollment application on or after January 1, 2022.
- (6) Meets and certifies in its CMS-approved enrollment application that it meets and will continue to meet the supplier enrollment standards described in paragraph (d) of this section.
- (7) Revalidates its Medicare enrollment every 5 years after the effective date of enrollment.
- (c) **MDPP preliminary recognition.** For the purposes of this section, an MDPP preliminary recognition may include either:
 - (1) Any preliminary recognition established by CDC for the purposes of the DPRP; or
 - (2) An MDPP interim preliminary recognition.
 - (i) **MDPP interim preliminary recognition application period.** Entities may apply to CDC for CMS' MDPP interim preliminary by submitting information at the time and in the form and manner specified by CMS.
 - (ii) **MDPP Interim preliminary recognition requirements.** An entity may qualify for MDPP interim preliminary recognition if—
 - (A) The entity has pending CDC recognition.
 - (B) The entity submits a full 12 months of performance data to CDC on at least one completed cohort. The 12 month data submission includes at least 5 participants who attended at least 3 sessions in the first 6 months and whose time from first session attended to last session of the lifestyle change program was at least 9 months, at least 60 percent of whom attended at least 9 sessions in months 1 through 6, and at least 60 percent of whom attended at least 3 sessions in months 7 through 12.
- (d) **Medicare Diabetes Prevention Program supplier standards.** An MDPP supplier must meet and must certify in its CMS-approved enrollment application that it meets and will continue to meet the following standards.
 - (1) The MDPP supplier must have and maintain MDPP preliminary recognition, as defined under paragraph (c)(1) of this section, or a full CDC DPRP recognition.

- (2) The MDPP supplier must not currently have its billing privileges terminated for-cause or be excluded by a State Medicaid agency.
- (3) The MDPP supplier must not include on the roster of coaches, described in paragraph (b)(4) of this section and updated in accordance with paragraph (d)(5) of this section, nor permit MDPP services to be furnished by, any individual coach who meets any of ineligibility criteria outlined in paragraph (e)(1) of this section.
- (4) The MDPP supplier must maintain at least one administrative location. All administrative locations maintained by the MDPP supplier must be located at an appropriate site and be reported on the CMS-approved enrollment application. An appropriate site for such an administrative location would include all of the following characteristics:
 - (i) Signage posted on the exterior of the building or suite, in a building directory, or on materials located inside of the building. Such signage may include, for example, the MDPP supplier's legal business name or DBA, as well as hours of operation.
 - (ii) Open for business during stated operational hours.
 - (iii) Employees, staff, or volunteers present during operational hours; and
 - (iv) Not a private residence.
- (5) The MDPP supplier must update its enrollment application within 30 days of any changes of ownership, changes to the coach roster (including due to coach ineligibility or because the coach is no longer an employee, contractor, or volunteer of the MDPP supplier), and final adverse action history, and report all other changes, including but not limited to changes in the MDPP supplier's administrative location(s), to CMS within 90 days of the reportable event.
- (6) The MDPP supplier must maintain a primary business telephone that operates either at administrative locations described in paragraph (d)(4) of this section or directly where services are furnished, if services are furnished in community settings. The associated telephone number must be listed with either the legal or doing business as name of the supplier in public view, including on Web sites, flyers, and materials.
- (7) The MDPP supplier must not knowingly sell to or allow another individual or entity to use its supplier billing number.
- (8) Subject to paragraph (d)(8)(i) of this section, the MDPP supplier must not deny an MDPP beneficiary access to MDPP services during the MDPP services period described in § 410.79(c)(2) of this chapter, including on the basis of the beneficiary's weight, health status, or achievement of performance goals.
 - (i) Suppliers may deny an MDPP beneficiary access to MDPP services during the MDPP services period only under one of the following conditions:
 - (A) The MDPP beneficiary no longer meets the eligibility criteria for MDPP services under § 410.79(c)(1) of this chapter.
 - (B) The MDPP supplier lacks the self-determined publicly-posted capacity to furnish MDPP services to a given MDPP beneficiary.
 - (C) The MDPP supplier determines that the MDPP beneficiary significantly disrupts the session for other MDPP beneficiaries or becomes abusive.

- (ii) MDPP suppliers must maintain a record of the number of MDPP beneficiaries for whom it declined access away for the reasons outlined in paragraphs (d)(8)(i)(B) and (C) of this section, to include the date each such beneficiary was declined access. For beneficiaries who were declined access for the reasons described in paragraph (d)(8)(i)(C) of this section, the MDPP supplier must document details of the occurrence(s), including date(s) of the behavior, any remediation efforts taken by the MDPP supplier, and final action (for example, dismissal from an MDPP session or denial from future sessions) in the beneficiary's MDPP records.
- (9) The MDPP supplier and other individuals or entities performing functions or services related to MDPP services on the MDPP supplier's behalf must not unduly coerce an MDPP beneficiary's decision to change or not to change to a different MDPP supplier, including through the use of pressure, intimidation, or bribery.
- (10) Except as allowed under paragraph (d)(8) of this section, the MDPP supplier must offer an MDPP beneficiary no fewer than all of the following:
 - (i) 16 in-person core sessions no more frequently than weekly for the first 6 months of the MDPP services period, which beginnings on the date of attendance at the first such core session.
 - (ii) 1 in-person core maintenance session each month during months 7 through 12 (6 months total) of the MDPP services period.
 - (iii) 1 in-person ongoing maintenance session each month for months 13 through 24 of the MDPP services period, as long as the beneficiary maintains eligibility to receive such services in accordance with § 410.79(c)(1)(ii) and (iii) of this chapter.
- (11) Before the initial core session is furnished, the MDPP supplier must disclose detailed information about the set of MDPP services to each MDPP beneficiary to whom it wishes to begin furnishing MDPP services. Such information must include all of the following:
 - (i) Eligibility requirements under § 410.79(c)(1) of this chapter, including the once-per-lifetime nature of MDPP services.
 - (ii) Minimum coverage requirements under § 410.79(c)(2).
 - (iii) The MDPP supplier standards as specified in paragraph (d) of this section.
- (12) The MDPP supplier must answer MDPP beneficiaries' questions about MDPP services and respond to MDPP-related complaints within a reasonable timeframe. An MDPP supplier must implement a complaint resolution protocol and maintain documentation of all beneficiary contact regarding such complaints, including the name and Medicare Beneficiary Identifier of the beneficiary, a summary of the complaint, related correspondences, notes of actions taken, and the names and/or NPIs of individuals who took such actions on behalf of the MDPP supplier. Failure to maintain a complaint resolution protocol or to retain information regarding MDPP related complaints in accordance with paragraph (g) of this section may be considered evidence that the MDPP supplier standards have not been met. This information must be kept at each administrative location and made available to CMS or its contractors upon request.
- (13) The MDPP supplier must maintain a crosswalk file which indicates how beneficiary identifications for the purposes of CDC performance data requirements correspond to corresponding beneficiary health insurance claims numbers or Medicare Beneficiary Identifiers for each MDPP beneficiary receiving MDPP services from the MDPP supplier. The MDPP supplier must submit the crosswalk file to CMS or its contractor.

- (14) The MDPP supplier must submit performance data for MDPP beneficiaries who attend ongoing maintenance sessions with data elements consistent with the CDC's DPRP standards for data elements required for the core services period.
- (15) The MDPP supplier must allow CMS or its agents to conduct onsite inspections or recordkeeping reviews in order to ascertain the MDPP supplier's compliance with these standards, and must adhere to the documentation requirements as outlined in paragraph (g) of this section.

(e) **Coach eligibility –**

- (1) **Criteria.** To furnish MDPP services to a beneficiary, an MDPP coach must not:
 - (i) Currently have Medicare billing privileges revoked and be currently subject to the reenrollment bar.
 - (ii) Currently have its Medicaid billing privileges terminated for-cause or be excluded by a State Medicaid agency.
 - (iii) Currently be excluded from any other Federal health care program, as defined in 42 CFR 1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.
 - (iv) Currently be debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the Federal Acquisition Streamlining Act implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.
 - (v) Have, in the previous 10 years, one of the following State or Federal felony convictions:
 - (A) Crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.
 - (B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.
 - (C) Any felony that placed Medicare or its beneficiaries at immediate risk, such as a malpractice suit that results in the individual being convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion of criminal neglect or misconduct.
 - (D) Any felonies for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion that would result in mandatory exclusion under section 1128(a) of the Act.
- (2) **CMS determination of coach eligibility.** CMS will screen each individual identified on the roster of coaches included with the supplier's enrollment application described in paragraph (b)(4) of this section and updated in accordance with paragraph (d)(5) of this section to verify that the individual coach does not meet any of the conditions specified in paragraph (e)(1) of this section and that the coach can provide MDPP services on behalf of an MDPP supplier. For each individual coach successfully screened by CMS, his or her eligibility start date becomes effective and remains effective until an MDPP supplier or CMS takes action that results in an eligibility end date.

(f) **Effective date for billing privileges.**

- (1) For MDPP suppliers initially enrolling and for newly established administrative locations that result in a new enrollment record or Provider Transaction Access Number, the effective date for Medicare billing privileges for MDPP suppliers is—
 - (i) The later of—
 - (A) The date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor;
 - (B) The date of filing of a corrective action plan that was subsequently approved by a Medicare contractor; or
 - (C) The date that the supplier first began furnishing services at a new administrative location that resulted in a new enrollment record or Provider Transaction Access Number.
 - (ii) Under no circumstances should the effective date of billing privileges for any MDPP supplier be prior to April 1, 2018.
 - (2) For any newly established administrative locations that do not result in a new enrollment record or Provider Transaction Access Number, the existing billing privilege effective date for their Provider Transaction Access Number will apply, but not earlier than April 1, 2018.
- (g) **Documentation retention and provision requirements.** An MDPP supplier must maintain all documentation related to participation in the MDPP in accordance with all applicable Federal and State laws. The MDPP supplier must provide to CMS, a contractor acting on CMS' behalf, the Office of the Inspector General, and the Comptroller General or their designee(s) scheduled and unscheduled access to the MDPP supplier's records, including, but not limited to, all books, contracts, records, documents, and other evidence sufficient to enable the audit, evaluation, inspection, or investigation of the MDPP supplier's compliance with the MDPP expanded model's requirements, including the MDPP expanded model requirements for in-kind beneficiary incentive engagements in § 424.210 of this chapter in the event that the MDPP supplier chooses to offer such incentives to any MDPP beneficiary.
- (1) The documentation for the first core session must be established contemporaneous with the furnishing of MDPP services and must include at least all of the following:
 - (i) Organizational information, including MDPP supplier name, CDC DPRP number, and NPI.
 - (ii) Basic beneficiary information for each MDPP beneficiary in attendance, including but not limited to beneficiary name, HICN, or MBI, age.
 - (iii) Evidence that each such beneficiary satisfied the eligibility requirements under § 410.79(c) of this chapter at the time of service.
 - (2) The documentation for each MDPP session attended by an MDPP must be established contemporaneous with the furnishing of MDPP services and must include at least all of the following:
 - (i) Documentation of the type of session, whether a core session, a core maintenance session, an ongoing maintenance session, an in-person make-up session, or a virtual make-up session.
 - (ii) Identification of which CDC-approved DPRP curriculum was associated with the session.
 - (iii) The NPI of the coach who furnished the session.
 - (iv) The date and place of service of the session.

- (v) Each MDPP's beneficiary's weight and date weight taken, in a form and manner as specified by CMS.
- (3) If an MDPP supplier chooses to offer in-kind beneficiary engagement incentives to MDPP beneficiaries as permitted under § 424.210, the records maintained by the MDPP supplier in accordance with this section must also include the information required by § 424.210(e).
- (4) An MDPP supplier is required to maintain and handle any beneficiary information related to MDPP, including Personally Identifiable Information (PII) and Protected Health Information (PHI), as would be required under HIPAA, other applicable state and federal privacy laws, and CMS standards.
- (5) The MDPP supplier's records must include an attestation from the MDPP supplier that, as applicable, the MDPP beneficiary for which it is submitting a claim—
 - (i) Has attended their first, fourth or ninth core session, as applicable, if the claim submitted is for a performance payment under § 414.84(b)(1), (2), or (3) of this chapter.
 - (ii) Has attended at least three core maintenance sessions, achieved required minimum weight loss, or both, as applicable, if the claim submitted is for a performance payment under § 414.84(b)(4) of this chapter.
 - (iii) Has achieved the required minimum weight loss and attended at least three ongoing maintenance sessions within an ongoing maintenance session interval, if the claim submitted is for a performance payment under § 414.84(b)(5) of this chapter, if the claim submitted is for a performance payment under § 414.84(b)(6) of this chapter.
 - (iv) Has achieved required minimum weight loss as measured in-person during a core session or core maintenance session furnished by that supplier, if the claim submitted is for a performance payment under § 414.84(b)(6) of this chapter.
 - (v) Has achieved at least a 9-percent weight loss percentage as measured in-person during a core session, core maintenance session, or ongoing maintenance session furnished by that supplier, if the claim submitted is for a performance payment under § 414.84(b)(7) of this chapter.
- (6) The MDPP supplier must maintain all records required under this section for a period of 10 years from the last day of the MDPP beneficiary's receipt of MDPP services provided by the MDPP supplier or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless either of the following apply:
 - (i) CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies the MDPP supplier at least 30 calendar days before the normal disposition date; or
 - (ii) There has been a dispute or allegation of fraud or similar fault against the MDPP supplier, in which case the records must be maintained for an additional 6 years from the date of any resulting final resolution of the dispute or allegation of fraud or similar fault, as defined at § 405.902 of this chapter.
- (h) **Denial or revocation of MDPP supplier enrollment.**
 - (1) An MDPP supplier is subject to enrollment denial or revocation of its MDPP supplier enrollment for one or more of the following reasons:

- (i) **Failure to meet enrollment requirements.** The MDPP supplier does not satisfy the conditions specified in paragraph (b) of this section.
 - (A) An enrollment denial under this paragraph (h)(1)(i) is considered an enrollment denial under § 424.530(a)(1).
 - (B) A revocation under this paragraph (h)(1)(i) is considered a revocation under § 424.535(a)(1).
 - (C) An MDPP supplier that does not satisfy the requirements in paragraph (b)(1) of this section may become eligible to bill for MDPP services again if it successfully achieves MDPP preliminary recognition or full CDC DPRP recognition, and successfully enrolls again in Medicare as an MDPP supplier after any applicable reenrollment bar has expired.
- (ii) **Failure to meet MDPP supplier standards.** The MDPP supplier fails to meet the standards specified in paragraph (d) of this section.
 - (A) An enrollment denial under this paragraph (h)(1)(ii) is considered an enrollment denial under § 424.530(a)(1).
 - (B) A revocation under this paragraph (h)(1)(ii) is considered a revocation under § 424.535(a)(1).
- (iii) **Application of existing enrollment denial reasons.** One of the enrollment denial reasons specified in § 424.530(a) applies.
- (iv) **Application of existing revocation reasons.** One of the revocation reasons specified in § 424.535(a) applies.
- (v) **Use of an ineligible coach.**
 - (A) The MDPP supplier knowingly allows an ineligible coach to furnish MDPP services to Medicare beneficiaries. Knowingly means that the MDPP supplier received an enrollment denial or revocation notice based on failing to meet the standard specified in § 424.205(d)(3), was provided notice by CMS or contractors working on its behalf of this coach's ineligibility including the reason(s) for ineligibility, submitted a corrective action plan (CAP) to remove the coach and become compliant therefore maintaining its enrollment, but continued to allow the coach to provide MDPP services in violation of the CAP.
 - (B) Revocation under this paragraph (h)(1)(v) is subject to the following requirements:
 - (1) The revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the MDPP supplier.
 - (2) For the revocation authority under this paragraph (h)(1)(v), MDPP suppliers are barred from participating in the Medicare program from the date of the revocation, which begins 30 days after CMS or its contractor mails notice of the revocation, until the end of the reenrollment bar, which lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation.
 - (3) A revoked MDPP supplier must, within 60 calendar days after the effective date of revocation, submit all claims for items and services furnished before the date of the revocation letter.

- (2) An MDPP supplier may appeal an enrollment denial or revocation decision in accordance with the procedures specified in part 498 of this chapter. References to suppliers in that section apply to MDPP suppliers.

[82 FR 53364, Nov. 15, 2017, as amended at 86 FR 65682, Nov. 19, 2021]

Version 04/25/2024
Check for Updates

Medicare Diabetes Prevention Program (MDPP) 12 - 26

2024 Medicare FFS Billing and Payment Fact Sheet

Calendar Year (CY) 2024 MDPP expanded model regulations allow for fee-for-service (FFS) payments for beneficiary attendance as well as performance-based payments for diabetes risk reduction (weight loss). This fact sheet explains the billing process for MDPP services, including changes to the MDPP payment schedule in the [CY 2024 Physician Fee Schedule \(PFS\)](#), and provides tips on how to submit claims and where to get help along the way. This resource is relevant to MDPP-related claims for dates of service beginning January 1, 2024. For guidance on MDPP-related claims with dates of service on or before December 31, 2023, please see this [2020 Billing and Claims Cheat Sheet](#). MDPP suppliers may use the MDPP Medicare Advantage Fact Sheet or contact the beneficiary's Medicare Advantage plan for information on Medicare Advantage billing and payment.



1. Identify Your MAC



2. Understand Payment/Billing



3. Submit Your Claims



4. Payment/Next Steps



1. Identify Your Medicare Administrative Contractor (MAC)

What Are MACs?

MACs are contractors that, among other things, process Medicare enrollment applications and claims for FFS Medicare providers and suppliers. Activities performed by MACs include:

- Review and processing of enrollment applications
- Processing of FFS Medicare claims
- Responses to inquiries
- Provision of information on billing and coverage requirements

A supplier's MAC depends on the supplier's site location. For more information on how to identify your MAC, please visit the [Who are the MACs website](#) and search for the Part A/B MAC that serves your geographic area. Each MAC processes claims for certain states. If an MDPP supplier offers MDPP services in multiple states, the MDPP supplier may work with more than one MAC.

You should contact your MAC if you have questions about enrolling in Medicare or submitting MDPP claims.



2. Understand the Billing/Payment Structure

What the Centers for Medicare and Medicaid Services (CMS) Pays for

Medicare pays MDPP suppliers for furnishing the MDPP Set of services to eligible beneficiaries using FFS payments. Suppliers may also receive performance-based payments when participants achieve diabetes risk reduction (weight loss) milestones.

MDPP Billing and Payment Quick Facts

- An organization must be separately enrolled in Medicare as an MDPP supplier to bill for MDPP services. Even if you are already enrolled in Medicare as a different provider type, you must also enroll as an MDPP supplier to bill for MDPP services.
- MDPP suppliers may electronically submit claims to a MAC for each session that a beneficiary attends (up to 22 sessions). Suppliers may also submit claims for payment when beneficiaries achieve certain performance milestones.
- Eligible MDPP beneficiaries are *not* required to pay anything out-of-pocket for MDPP services. MDPP suppliers must accept Medicare's payment for MDPP services as payment in full and cannot bill or collect any amount from MDPP beneficiaries.
- MDPP suppliers must collect beneficiary body weight measurements at each MDPP session to document baseline weight and achievement of any weight loss performance goals. Weight may be obtained in-person by the MDPP supplier, via digital technology (such as scales that transmit weights securely via wireless or cellular transmission), or self-reported by the beneficiary from an at-home digital scale.
- Suppliers may deliver all MDPP services virtually via distance learning, in person, or through a combination of in-person and distance learning delivery. Suppliers must maintain their Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) registration and be able to provide services in person, even if providing distance learning services only (i.e., the supplier must maintain an in-person DPRP organizational code).
- Distance learning sessions must be delivered by trained Lifestyle Coaches via live, synchronous delivery in a virtual classroom.

→ Core Sessions

- Beneficiaries may attend up to 16 weekly sessions during months 1-6 of the MDPP Core Services period.
- The MDPP Core Services period starts with the first claim for G9886 or G9887.
- Beneficiaries must attend one core session to initiate MDPP services.
- A supplier is paid based on the beneficiary's attendance, regardless of the beneficiary's weight loss.
- A supplier is paid performance payments if the beneficiary achieves weight-loss goals.



Core Maintenance Sessions

- Beneficiaries may attend up to 6 monthly sessions during months 7-12 of the MDPP Core Services period.
- A supplier is paid based on the beneficiary's attendance, regardless of the beneficiary's weight loss.
- A supplier is paid performance payments if the beneficiary achieves weight-loss goals and/or continues to meet the 5% weight-loss goal at each session.

	CORE SESSIONS	CORE MAINTENANCE SESSIONS
	MONTHS 1-6 (MAX 16 SESSIONS)	MONTHS 7-12 (MAX 6 SESSIONS)
Fee-For-Service Payments	G9886 (\$25): MDPP beneficiary attended a core session in-person, group, for 60 minutes G9887 (\$25): MDPP beneficiary attended a core session via distance learning, for 60 minutes	
Performance Payments	G9880 (\$145): MDPP beneficiary achieved 5 percent weight loss from baseline weight (billable once) G9881 (\$25): MDPP beneficiary achieved 9 percent weight loss from baseline weight (billable once) G9888 (\$8): MDPP beneficiary maintained 5 percent weight loss from baseline in months 7-12	
Other Payments	G9890 (\$25): Bridge payment: A one-time payment for the first MDPP core session or core maintenance session furnished by a new MDPP supplier when an MDPP beneficiary switches suppliers during months 1–12	

Healthcare Common Procedure Coding System (HCPCS) G-codes are **bolded** next to each payment description

Key Points to Remember

- Three G-codes can be used when submitting claims for beneficiary achievement of performance milestones: 1) 5% weight loss (G9880), 2) 9% weight loss (G9881), and 3) maintenance of 5% weight loss in a core maintenance session (G9888).
- Note that codes G9880 and G9888 cannot be used with the same date of service (DOS), and the DOS for code G9880 must occur prior to any DOS submitted for G9888. Claims for G9888 will be rejected by the MACs if 1) there is no claim for G9880 with a DOS prior to claim for G9888 and 2) DOS for G9888 is within the first 6 months of the MDPP services period.
- Suppliers may bill for a maximum of 22 sessions, including up to 16 weekly sessions in months 1-6, and up to 6 monthly sessions in months 7-12.
- Suppliers must use one of two G-codes (G9886 or G9887) when filing claims for attendance payments after every core and core maintenance session furnished to an MDPP beneficiary. Once the MACs have paid supplier(s) for 22 sessions for a beneficiary, any additional claims with DOS after the 22 paid claim will be rejected, including out-of-sequence claims.
- Each HCPCS G-code should be listed with the corresponding session DOS, MDPP organizational NPI, and rendering provider NPI. Note that the coach is the rendering provider on the claim.

If a Beneficiary Changes MDPP Suppliers

- Reach out to the HIPAA Eligibility Transaction System (HETS) to identify where the beneficiary is in their service timeline and get the beneficiary's MDPP records from the previous MDPP supplier to verify data (e.g., session attendance, baseline weight) before submitting any claims for performance payments. For more information please see the MDPP Factsheet "How to Verify an MDPP Beneficiary's Medicare Coverage" (<https://www.cms.gov/priorities/innovation/files/x/mdpp-verify-medicare-coverage.pdf>).
- Submit a claim for a bridge payment (G9890) for the first session furnished to the transferring beneficiary as well as a claim for that session (G9886 or G9887). This is only allowed if your organization did not furnish the first core session to that beneficiary. More than one supplier may submit a claim for the bridge payment for the same beneficiary once.



3. Submit Your Claims

MDPP suppliers (or their billing agents) are responsible for submitting all FFS claims to their MAC. You must use the 837P form to transmit health care claims electronically (<https://www.cms.gov/files/document/mln006976-medicare-billing-837p-form-cms-1500.pdf>), or the CMS-1500 form (the paper version of the 837P form). To submit a CMS-1500 form you must submit an Administrative Simplification Compliance Act (ASCA) waiver (<https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCASelfAssessment>). 98% of Medicare FFS providers/suppliers submit their claims electronically for a faster processing time.

How to Submit Claims

Timely submission of claims is **highly** encouraged. File claims as soon as possible by self-submitting or utilizing a vendor/third party billing agent. MDPP suppliers, like all other FFS Medicare providers, can file claims up to 12 months from the date of service. Your claim will be denied if you file it 12 months or later after the date of service. Please contact your MAC if you have questions about submitting MDPP claims.



Self-Submit Claims

If an MDPP supplier does not use a billing agent, the MDPP supplier can submit claims to its MAC directly. **The MDPP supplier must install claims software and obtain a submitter ID from the MAC(s).** Organizations may obtain PC-Ace Pro 32 claims submission software or other recommended software from their MAC(s).

Note: Please contact your MAC for additional information on claims software.



Use a Vendor/Third-Party Billing Agent

Providers and suppliers may use a third-party billing agent to manage billing and payment processes on their behalf. If an MDPP supplier uses a billing agent, the billing agent's information must be listed on the MDPP Enrollment Application (<https://pecos.cms.hhs.gov/pecos/login.do#headingLv1f>).

Include the following information on each claim form

• Demo Code – Only enter the number, 82, on the form
• Billing Provider/MDPP supplier organizational National Provider Identifier (NPI): Organizations should obtain a separate NPI to use for MDPP enrollment, in order to reduce claim rejections and denials that may occur if multiple enrollments are associated with a single NPI. Currently enrolled MDPP suppliers may obtain a separate NPI to use for their MDPP enrollment and can update their current enrollment with their new NPI in PECOS. In the event that an organization is unable to obtain a separate NPI or continues to encounter issues related to claims submission and processing after updating its enrollment with the new NPI, the organization should contact its MAC for assistance.
• Rendering Provider/Coach
• ICD-10 diagnosis code: MDPP claims, like all other types of claims, must include an International Classification of Diseases, 10th Revision (ICD-10) diagnosis code. MDPP suppliers can get the appropriate ICD-10 diagnosis code from a referral. However, MDPP does not require a referral, so the MDPP supplier can use the most appropriate ICD-10 code that captures the nature of the encounter (e.g., Z71.89, Other specified counseling).
• Date of service (DOS) for each MDPP session
• Beneficiary first name, last name, and Medicare Beneficiary Identifier (MBI)
• HCPCS G-Code for each MDPP service
• Place of Service (POS) code to indicate where the MDPP service was furnished, e.g., “Office” (11), “Outpatient Facility Code” (19 or 22), or “Other” (99) if the service was furnished in a community setting or as a distance learning session.

MDPP suppliers may have mixed cohorts and may serve both Medicare beneficiaries and participants who are not Medicare beneficiaries. Eligible MDPP beneficiaries are not required to pay anything out-of-pocket for MDPP services. MDPP suppliers must accept Medicare's payment for MDPP services as payment in full and cannot bill or collect any amount from the beneficiary.

- MDPP suppliers should submit claims only for eligible MDPP beneficiaries. Medicare only covers MDPP services for eligible Medicare beneficiaries.
- To learn how to verify an MDPP beneficiary's Medicare coverage, visit:
<https://innovation.cms.gov/Files/x/mdpp-verify-medicare-coverage.pdf>.



4. Receive Payment and Next Steps

How will suppliers receive payments?

- MDPP suppliers will get payments via Electronic Funds Transfer (EFT):
<https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/EFT.html>.
- MDPP suppliers must complete an EFT form as a part of the initial MDPP enrollment. For changes to your EFT account, please contact your MAC.
- If there are no issues with the claim, MDPP suppliers will be paid no sooner than 13 days after filing electronically (payment on the 14th day or after). Paper-based claims are paid no sooner than 28 days after filing (payment on the 29th day or after).

Post-Claims Submission

- After the MAC processes the claim, MDPP suppliers or the supplier's billing agent will get either an Electronic Remit Advice (ERA) at <https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.html> or a Standard Paper Remit (SPR) with final claim adjudication and payment information. An ERA or SPR usually:
 - Includes itemized adjudication decisions about multiple claims
 - Reports the reason and value of each adjustment to the billed amount on the claim

Issues with Payment

When you receive the denied or returned claim from the MAC, review the documentation sent from the MAC. Suppliers should contact their MACs for claims-specific questions. For more information on locating your MAC, visit the [Who are the MACs website](#).

If a MAC rejects a claim as unable to be processed

The MDPP supplier or the supplier's billing agent must correct the errors and submit a new claim.

If a MAC denies a claim

An MDPP supplier or the supplier's billing agent can file an appeal if they think the claim was denied incorrectly. Check your MAC's website for more information on how to appeal a denied claim.

Helpful Resources

MACS

- [What's a MAC?](#)
- [Find my MAC's contact information](#)
- [Who are the MACs?](#)
- [A/B MAC Jurisdiction Map](#)

Claims Submission

- [MDPP Eligibility Verification](#)
- [837P and CMS -1500 Forms Information](#)
- [837P and Form CMS-1500 Web-Based Training](#) (note: requires login to the Medicare Learning Network)
- [Medicare Claims Processing Manual](#)
- [Electronic Health Care Claims](#)
- [Sessions Journey Map](#)

Payment

- [PFS 2024 MDPP Changes Factsheet](#)
- [CMS Transmittals website](#)
- [MDPP Medicare Advantage Fact Sheet](#)

MDPP

- [MDPP Website](#)
- [Enrollment Preparation Guide](#)

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12410	Date: December 13, 2023
	Change Request 13484

SUBJECT: Updating Calendar Year (CY) 2024 Medicare Diabetes Prevention Program (MDPP) Payment Rates

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct A/B MACs (Part B) and the Railroad Specialty MAC on the updated MDPP Expanded Model payment rates for CY 2024 from the CY2024 PFS that was published November 16, 2023.

EFFECTIVE DATE: January 1, 2024

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 2, 2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 12410	Date: December 13, 2023	Change Request: 13484
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SUBJECT: Updating Calendar Year (CY) 2024 Medicare Diabetes Prevention Program (MDPP) Payment Rates

EFFECTIVE DATE: January 1, 2024

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 2, 2024

I. GENERAL INFORMATION

A. Background: The MDPP Expanded Model is an expansion of the Centers for Medicare & Medicaid Services (CMS') Diabetes Prevention Program (DPP) model test, which was tested from 2012-2015 under the authority of section 1115A(b) of the Social Security Act (the Act). The Secretary of Health and Human Services expanded the DPP model test in duration and scope under the authority of section 1115A(c) of the Act. Following certification of the DPP model test by the Chief Actuary in March 2016, the Center for Medicare and Medicaid Innovation (CMMI) expanded the model nationwide through the CY 2017 and 2018 Medicare Physician Fee Schedule (PFS) final rules. MDPP suppliers began enrolling in Medicare on January 1, 2018 and could begin furnishing MDPP services and billing Medicare for MDPP services on April 1, 2018. The MDPP Expanded Model is intended to prevent Medicare beneficiaries with an indication of prediabetes from developing diabetes. Prevention of diabetes among this high-risk group of Medicare beneficiaries is expected to result in significant cost savings to the Medicare program as certified by the Office of the Actuary.

B. Policy: In the CY 2018 Physician Fee Schedule final rule, CMS stated, "the [MDPP] performance payments and bridge payment will be adjusted each calendar year by the percent change in the Consumer Price Index for All Urban Consumers (CPI-U) (U.S. city average) for the 12-month period ending June 30th of the year preceding the update year. The percent change update will be calculated based on the level of precision of the index as published by the Bureau of Labor Statistics and applied based on one decimal place of precision. The annual MDPP services payment update will be published by CMS transmittal."

This means that the MDPP payment rates will be adjusted each calendar year based on the CPI-U. Payment rates will be in effect each year from January 1st through December 31st. CMS intends to calculate the payment rates for each calendar year and instruct the A/B Medicare Administrative Contractors (MACs) (Part B) and the Railroad Specialty MAC to manually update the MDPP payment rates each year through a non-systems instructional Change Request (CR).

In the CY 2024 PFS that was published 11/16/2023, CMS updated the MDPP payment structure to shift the performance-based attendance payments to a fee-for-service structure while retaining the diabetes risk reduction performance payments (e.g., 5% and 9% weight loss). To reflect this change, we finalized the creation of three new G-codes, 1) Behavioral Counseling for Diabetes prevention, in-person, group (G9886) ; 2) Behavioral Counseling for Diabetes prevention, distance learning (G9887); and 3) Maintenance of 5% weight loss from baseline in months 7-12 (G9888), and calculated the MDPP payment rates for 2024 to reflect these changes.

This CR contains instructions to A/B MACs (Part B) and the Railroad Specialty MAC on the updated MDPP Expanded Model payment rates.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			D M E	Shared-System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
13484.1	The A/B MACs (Part B) and the Railroad Specialty MAC shall manually update the CY 2024 payment rates for the 6 valid MDPP Healthcare Common Procedure Coding System (HCPCS) G-codes based on the payment rates found in the attached document. These rates must be in effect for dates of service January 1, 2024 through December 31, 2024.		X							RRB-SMAC	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H		
13484.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.		X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

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Medicare Diabetes Prevention Program (MDPP) Expanded Model

HCPCS G-Codes CY 2024

Payment Description		CY 2024
HCPCS G-Code	Service Payments for Attendance	Payment Rate
G9886	Behavioral counseling for diabetes prevention, in-person, group, 60 minutes	\$25
G9887	Behavioral counseling for diabetes prevention, distance learning, group, 60 minutes	\$25
	Performance Payments	
G9880	5% WL Achieved from baseline weight	\$145
G9881	9% WL Achieved from baseline weight	\$25
G9888	Maintenance 5% WL from baseline weight in months 7-12	\$8
	Bridge Payments	
G9890	Bridge Payment	\$25

**Medicare pays up to 22 visits billed with codes G9886 and G9887, combined, in a 12-month period:

- Months 1-6: one in-person/distance learning visit every week (up to 16)
- Months 7-12: one in-person/distance learning visit every month (up to 6)
- Months 7-12, once participant achieves 5% WL, supplier may submit Maintenance of 5% WL claim with attendance claim (G9888 + G9886/G9887). Medicare will pay for Maintenance 5% WL up to 6 times in months 7-12.

MDPP Expanded Model HCPCS G-Codes CY 2024

HCPCS G-Code	Long Descriptor	CY 2024 Payment Amount
G9886	An <i>in-person</i> Medicare Diabetes Prevention Program (MDPP) core or core maintenance session was attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core or core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions. Up to 22 sessions (alone or in combination with G9887) are allowed in a 12- month timeframe.	\$25
G9887	A Medicare Diabetes Prevention Program (MDPP) core or core maintenance session was attended via <i>distance learning</i> by an MDPP beneficiary under the MDPP Expanded Model (EM). A core or core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions. Up to 22 sessions (alone or in combination with G9886) are allowed in a 12- month timeframe.	\$25
G9880	The MDPP beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight in months 1-12 of the MDPP services period under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by a weight measurement at a core session or core maintenance session.	\$145
G9881	The MDPP beneficiary achieved at least 9% weight loss (WL) from his/her baseline weight in months 1-12 under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by a weight measurement at a core session or core maintenance session.	\$25
G9888	The MDPP beneficiary maintained at least 5% weight loss (WL) from their baseline weight, as measured by at least one weight measurement at a core maintenance session in months 7-12. The claim for 5% weight loss from baseline (G9880) must be submitted prior to the claim for maintenance of 5% weight loss from baseline in months 7-12. G9888 is allowed alone or in combination with G9886/G9887 as long G9888 has the same date of service as G9886/G9887, and the beneficiary has maintained 5% WL from baseline at the core maintenance session. G9888 may be billed up to 6 times in months 7-12.	\$8
G9890	Bridge Payment: A one-time payment for the first Medicare Diabetes Prevention Program (MDPP) core session or core maintenance session furnished by an MDPP supplier to an MDPP beneficiary during months 1-12 of the MDPP Expanded Model who has previously received MDPP services from a different MDPP supplier under the MDPP Expanded Model. G9890 is allowed alone or in combination with G9886/G9887. A supplier may only receive one bridge payment per MDPP beneficiary.	\$25

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