

DIABETES PREVENTION PROGRAM
Date of origin: May 28, 2026
Review dates: None yet recorded
DEFINITION

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program recognized by the Centers for Disease Control and Prevention (CDC). The program applies to adults over the age of 18 with prediabetes or at risk to develop type 2 diabetes.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD [in our Provider Manual](#).

POLICY SPECIFIC INFORMATION
Coding specifics

CPT Code	CPT Description
G9871	Behavioral counseling for diabetes prevention, online, group, 60 minutes
G9880	The DPP beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight in months 1-12 of the DPP 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. The MDPP expanded model allows participants to self-report weight for distance learning sessions until Dec. 31, 2027.
G9881	The DPP 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. The MDPP expanded model allows participants to self-report weight for distance learning sessions until Dec. 31, 2027.
G9886	Behavioral counseling for diabetes prevention, in-person, group, 60 minutes
G9887	Behavioral counseling for diabetes prevention, distance learning, 60 minutes

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/online every week (max 16 sessions)
- Months 7-12: one in-person / distance learning/online visit ever month (max 6 sessions)
- Months 7-12, once the participant achieves 5% WL, you may submit a Maintenance of 5% WL claim with an attendance claim (G9888 + G9886/G9887 + G9871). Medicare will pay for G9888 up to 6 times in months 7-12.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information [in our Provider Manual](#).

For claims related to virtual or community sessions, use place of service code 99 ("Other").

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Resources

<https://www.medicare.gov/coverage/medicare-diabetes-prevention-program>

<https://www.priorityhealth.com/provider/manual/services/preventive-care/dpp-participation/reimbursement>

<https://www.cms.gov/priorities/innovation/innovation-models/medicare-diabetes-prevention-program/faq#billing>

Related denial language

- Pe9 - Dx code does not meet medical necessity

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise

detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

CHANGE / REVIEW HISTORY

Date	Revisions made
May 2026	New policy