



# PHARMACIST PROVIDER STATUS WISCONSIN MEDICAID

## BILLING CODE GUIDE

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### Supported by

PSW Ambulatory Care  
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TEAMING UP FOR BETTER PATIENT CARE  
Pharmacist Provider Status

### Authors

Jennifer Foti, PharmD, BCACP  
Matt Huppert, PharmD  
Kari Trapskin, PharmD

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Julie Bartell, PharmD, BCACP, FPSW

Amanda Mauerman, PharmD, BCACP

Nicole Green, BSP, RPh, ACPR, DPLA

Nicholas Olson, PharmD, BCACP, FPSW

Tyler Ho, PharmD, BCACP

Sarah Ray, PharmD, BCPS, FAPhA

Abbigail Linde, PharmD, CDCES, CKNS

Jennifer Slaughter, PharmD, BCACP

Amy Mahlum, PharmD, BCACP

Christa Wilson, PharmD

## DISCLAIMERS

- The content included within this document is not all-inclusive and provides 2024 reimbursement rate estimations. These reimbursement rates are subject to change. Please refer to the Wisconsin Forward Health Search Function and [Max Fee Dynamic Search \(wi.gov\)](#) for up-to-date information.
  - » The Forward Health max fee schedule displays allowable rendering providers. For some services, both Provider Type (PT) 23 (Pharmacist) and Provider Type (PT) 24 (Pharmacy) are listed. When PT24 is displayed as an allowable provider type, the pharmacy can bill for the service without submitting an additional rendering provider NPI on the claim for the claim to process. For services displaying PT23 on the max fee schedule, the pharmacy could bill the claim but must include an enrolled pharmacist NPI as the rendering provider. The system was built to allow the pharmacy/pharmacist billing/rendering provider combination, such that anytime PT23 is the renderer and PT24 is the biller, the claim will process.<sup>1</sup>
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- Not all CPT codes listed within this document are deemed billable by certain health care organizations. Work with your compliance department within your health care organization to determine ability to submit claims for specific codes.

### Special Coverage Considerations Legend

#	Age	^	Part of Nursing Home Daily Rate
!	Diagnosis	%	Prior Authorization
*	NDC		

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*This Pharmacist Provider Status Wisconsin Medicaid Billing Code Guide is intended to assist pharmacists in implementing pharmacist-provided medical service billing as permissible via 2021 Wisconsin Act 98, s. 49.46 (2) (bh), Stats. This information is not a substitute for professional training and judgment. Use of this information indicates acknowledgment that neither PSW nor its contributing authors will be responsible for any loss or injury, including death, sustained in connection with or as a result of using this information. PSW is under no obligation to update the information contained herein.*

*For a comprehensive guide on medical billing for pharmacists, please refer to the [Washington State Pharmacy Association Billing Guide](#).*

# INTRODUCTION

Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes are used to report medical services provided to patients to Medicaid and fiscal agents. HCPCS are made up of Level I and Level II codes. CPT codes are defined in the American Medical Association (AMA) CPT Professional. Level II codes are defined by the Centers for Medicare & Medicaid Services (CMS).<sup>2</sup>

## HCPCS/CPT Code Provider Guidance:

- HCPCS codes are used to report procedures, services, drugs and devices provided in the office, hospital outpatient facility, ambulatory surgical center, or other outpatient facility.<sup>3</sup>
- Procedures must be reported using the most comprehensive CPT code describing the services performed.
- Do not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes the services provided.
- Providers must avoid down-coding. If a HCPCS/CPT code exists to describe the services, this code must be reported rather than reporting a less comprehensive code with additional codes describing services not included.
- Providers must avoid up-coding. Only report a code if all services described by a code were actually performed.
- Providers must report unit of service (UOS) correctly. Each HCPCS/CPT code has a defined UOS used for reporting.<sup>2</sup>

## Evaluation & Management (E&M) Services:

- CPT codes for E/M services include 99202-99499. These codes define:
  - » Site of service (e.g., office, hospital, home, nursing facility, emergency department, etc.)
  - » Type of service (e.g., new or initial encounter, follow-up or subsequent)
  - » Various miscellaneous services (e.g., prolonged provider service, care plan oversight, etc.)<sup>4</sup>
- New vs. Established Patient E/M Codes
  - » Look-back period is 3 years
  - » New patients - have not received any professional services (i.e., E/M service or other face-to-face service) from you or your provider group within the past 3 years. This includes Wisconsin Pharmacy Quality Collaborative Comprehensive Medication Review and Assessment (WPQC CMR/A) services.
  - » Established patients - have received professional services (i.e., E/M service or other face-to-face service) from you or your provider group within the past 3 years. This includes WPQC CMR/A services.<sup>5</sup>
  - » For more information, see the [Medicare Claims Processing Manual](#), Chapter 12, Section 30.6.7.A.
- Always report codes that best characterize the services you provide during the visit:
  - » Your claim should correctly show your services
  - » The medical record documentation supports the level of service you report to a payer.<sup>3</sup>
- Services must meet the medical necessity guidelines in the statute, regulations, manuals and the medical necessity criteria in the [CMS National Coverage Determinations](#) (NCDs) and [Local Coverage Determinations](#) (LCDs) if any exist for the service reported on the claim.

For every service billed, you must show the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.<sup>3</sup>

- Documentation of each E/M service should include:
  - » Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
  - » Assessment, clinical impression, or diagnosis
  - » Medical care plan
  - » If you don't document the date, then include legible name of the observers and rationale for ordering diagnostic and services
  - » Past and present diagnoses should be accessible
  - » Identify appropriate health risk factors
  - » Patient progress, response to and changes in treatment, and revision of diagnosis
  - » Report diagnosis and treatment codes on the health insurance claim form or billing statement<sup>3</sup>
- Modifiers: Used to report a separate E/M service performed on the same date of service as another service
  - » Modifier 25: Used to identify a significant, separately identifiable E/M service by the same qualified health care professional on the same date as the other service provided.
    - The E/M service should be able to stand alone as a billable service
    - Documentation must demonstrate medical necessity of the E/M service
    - Use separate documentation for each service being billed within the medical record
    - Documentation should be able to support each service as if it were a standalone service<sup>5</sup>
  - » For more information on Add On Codes and modifiers, see [Medicare Claims Processing Manual](#), Chapter 12 and [AMA Reporting CPT Modifier 25](#), [Max Fee Dynamic Search \(wi.gov\)](#) and [Medicaid NCCI Policy Manual | CMS](#).

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): Please consult with your RHC or FQHC administration regarding the nuances of medical service coverage in each setting.<sup>6</sup>

# TIME-BASED & MEDICAL DECISION-MAKING E/M CODES

## Home or Residence Services<sup>7</sup>

- E/M services provided in private home (e.g., assisted living facility, group home, private residence, residential substance abuse treatment facility, temporary or short-term housing).
- Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies provided consistent with the nature of the problem(s) and the patient's and/or family's needs
- Billing is based on the time spent with the patient and/or family or caregivers or Medical Decision Making (MDM).<sup>7</sup>

Billing Code	Description	Reimbursement Rate <sup>1</sup>
<b>New Patient</b>		
99341 <sup>1</sup>	Straightforward MDM or at least 15 minutes total time	\$21.21
99342	Low level MDM or at least 30 minutes total time	\$30.32
99344	Moderate level MDM or at least 60 minutes total time	\$130.94
99345	High level MDM or at least 75 minutes total time	\$162.08
<b>Established Patient</b>		
99347 <sup>1</sup>	Straight forward MDM or at least 20 minutes total time	\$36.01
99348	Low level MDM or at least 30 minutes total time	\$57.15
99349	Moderate level MDM or at least 40 minutes total time	\$86.61
99350	High level MDM or at least 60 minutes total time	\$130.94

## Nursing Facility Services<sup>4,7</sup>

- E/M services provided in nursing facilities (e.g., skilled nursing facilities (SNFs), intermediate care facilities (ICFs), long-term care facilities (LTC), or psychiatric residential treatment centers).
- Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
- Billing is based on time spent at bedside and on the patient's facility floor or unit.<sup>7</sup>
- Reimbursement for one routine nursing home visit per calendar month per member.
- Must use the most appropriate CPT procedure code based on the level of service provided.<sup>4</sup>
- For more information, reference: [Forward Health Online Handbook - Topic #481: A Comprehensive Overview](#)

Billing Code	Description	Reimbursement Rate <sup>1</sup>
<b>Subsequent Nursing Facility Care</b>		
99309 (30 minutes)	Subsequent nursing facility care, per day <ul style="list-style-type: none"> <li>• Requires a medically appropriate history and/or examination and moderate level of medical decision making</li> </ul>	\$60.28
<b>Nursing Facility Day of Discharge Management</b>		
99315 (<30 minutes)	Nursing facility discharge day management ( <i>30 minutes or less</i> )	\$49.15
99316 (>30 minutes)	Nursing facility discharge day management ( <i>more than 30 minutes</i> )	\$64.87

# TIME-BASED & MEDICAL DECISION-MAKING OFFICE OR OUTPATIENT SERVICE E/M CODES

## Office or Outpatient Services<sup>7,8</sup>

CMS documentation guidelines – required to report total time spent, both face-to-face and non-face-to-face, on the date of the encounter.

Reimburses only one office visit per member, per provider, per Date of Service (DOS). However, an E/M office visit may be reimbursed in addition to a preventive medicine visit by the same provider on the same DOS.

A provider may be reimbursed for counseling (including counseling a member for available courses of treatment) using E/M office visit procedure codes 99202–99215, even if counseling was the only service provided during the visit. Counseling may include the discussion of treatment options that are not covered (for example, experimental services).

Providers are required to retain in their records whether they are billing using Medical Decision Making (MDM) or time. If providers bill for time, total time must be reflected in the documentation.<sup>7</sup>

Office Location:

- Pharmacy: use Place of Service (POS) 01
- Ambulatory Clinic office: use POS 11
- On-campus outpatient hospital facility office: use POS 22
- Off-campus outpatient hospital facility office: use POS 19

All documentation must be completed prior to submission of the claim.<sup>8</sup>

For more information: [Forward Health Online Handbook - Topic #481: A Comprehensive Overview](#)

Billing Code	Description	Reimbursement Rate <sup>1</sup>
<b>New Patient</b>		
<b>99202<sup>#</sup></b> (15-29 minutes)	Requires medically appropriate history and/or exam and straightforward medical decision making.	\$43.52
<b>99203<sup>#</sup></b> (30-44 minutes)	Requires medically appropriate history and/or exam and low level of medical decision making.	\$66.93
<b>99204<sup>#</sup></b> (45-59 minutes)	Requires medically appropriate history and/or exam and moderate level of medical decision making.	\$99.86
<b>99205<sup>#</sup></b> (60-74 minutes)	Requires medically appropriate history and/or exam and high level of medical decision making.	\$131.77
<b>Established Patient</b>		
<b>99211<sup>#</sup></b>	Does not require presence of physician or other qualified health care professional. <ul style="list-style-type: none"> <li>• Presenting problem is minimal.</li> </ul>	\$14.06
<b>99212<sup>#</sup></b> (10-19 minutes)	Requires medically appropriate history and/or exam and straightforward medical decision making.	\$34.00
<b>99213<sup>#</sup></b> (20-29 minutes)	Requires medically appropriate history and/or exam and low level of medical decision making.	\$54.39
<b>99214<sup>#</sup></b> (30-39 minutes)	Requires medically appropriate history and/or exam and moderate level of medical decision making.	\$77.00
<b>99215<sup>#</sup></b> (40-54 minutes)	Requires medically appropriate history and/or exam and high level of medical decision making.	\$107.96

See **Appendix A** for E&M Level of Medical Decision Making (MDM) Table

# CHRONIC CARE SERVICES

## Anticoagulation Management/Home and Outpatient International Normalized Ratio (INR) Monitoring<sup>7</sup>

Billing Code	Description	Reimbursement Rate <sup>1</sup>
93793	Warfarin Anticoagulation Management <ul style="list-style-type: none"> <li>Requires review and interpretation of a new home, office, or lab INR result</li> <li>Provide patient instructions, dosage adjustment (as needed) and scheduling of additional test(s)</li> <li>Can bill non-face-to-face assessment and management of INR</li> <li>Can only be used once per day</li> </ul>	\$8.40
G0250	Home INR Testing & Interpretation <ul style="list-style-type: none"> <li>Review, interpretation, and patient management of home INR testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria</li> <li>Testing not occurring more frequently than once per week; billing units of service include 4 tests</li> </ul>	\$6.63

## Cardiology<sup>6</sup>

Billing Code	Description	Reimbursement Rate <sup>1</sup>
93268 <sup>^</sup>	Electrocardiogram (ECG) Record & Review	\$216.71
93271	ECG Monitoring & Analysis	\$195.73

## Chronic Care Management Education & Training for Self-Care<sup>7</sup>

Billing Code	Description	Reimbursement Rate <sup>1</sup>
98961 (30 minutes)	Education and training for patient self-management using standardized curriculum. <ul style="list-style-type: none"> <li>Face-to-face with patient/caregiver/family member</li> <li><b>Group 2-4 patients;</b> billed to each patient</li> </ul>	\$14.00
98962 (30 minutes)	Education and training for patient self-management using standardized curriculum. <ul style="list-style-type: none"> <li>Face-to-face with patient/caregiver/family member</li> <li><b>Group 5-8 patients;</b> billed to each patient</li> </ul>	\$12.95

## Diabetes<sup>7,10</sup>

### Continue Glucose Monitoring (CGM):

- Professional CGM utilizing provider-owned equipment is covered for BadgerCare Plus and Medicaid members as a supplement to standard care for diabetes when the primary care provider or attending provider determines such monitoring is medically necessary to establish an optimal insulin regimen.
- Documentation: Must include medical necessity of professional CGM to establish optimal insulin regimen for insulin-dependent patient and documented inadequate glycemic control. Documentation must include monitor calibration, member training, sensor removal, record printout, and provider report with interpretation from monitoring information.<sup>10</sup>

95249 and 95250 should not be billed on date of CGM placement. They should be billed during the follow-up encounter if 72 hours of CGM data are recorded.

- If interpretation is also being done at this follow-up visit, then 95249/95250 should be billed in addition to 95251 with modifier 25.

For more information, reference: [Forward Health Online Handbook - Topic #17897: Continuous Glucose Monitoring](#)

Billing Code	Description	Reimbursement Rate <sup>1</sup>
95249	Patient-provided CGM - Ambulatory continuous glucose monitoring (CGM) via sensor for a minimum of 72 hours <ul style="list-style-type: none"> <li>Includes sensor placement, hook-up, calibration, training, and printout of recording</li> <li><b>Can only bill once per receiver</b></li> <li>Do not report in conjunction with 99091</li> <li>Do not report for subsequent episodes of data collection, unless patient obtains a new and/or different model of receiver</li> <li>Do not report unless the patient brings the receiver to the provider's office with the entire initial data collection; procedure conducted in office (<i>i.e., cannot bill without data</i>)</li> </ul>	\$38.22
95250	Office-provided CGM - Ambulatory continuous glucose monitoring (CGM) via sensor for a minimum of 72 hours <ul style="list-style-type: none"> <li>Includes sensor placement, hook-up, calibration, training, and printout of recording</li> <li>May be reimbursed up to four times per year but may not be reimbursed more than once per month.</li> </ul>	\$49.79
95251	Interpretation - Ambulatory continuous glucose monitoring (CGM) via sensor for a minimum of 72 hours <ul style="list-style-type: none"> <li>Analysis, interpretation and report</li> <li>May be reimbursed up to four times per year but may not be reimbursed more than once per month.</li> <li>Does not require a face-to-face visit</li> <li>Do not report in conjunction with 99091</li> </ul>	\$23.35

## Hypertension<sup>7,10</sup>

Billing Code	Description	Reimbursement Rate <sup>1</sup>
93784	Ambulatory Blood Pressure Monitoring with report-generating software – <ul style="list-style-type: none"> <li>Automated, worn continuously for 24 hours or longer</li> <li>Includes recording, scanning analysis, interpretation and report</li> </ul>	\$62.65
93786	Ambulatory Blood Pressure Monitoring with report-generating software – <ul style="list-style-type: none"> <li>Recording only (reported on the date monitoring is completed)</li> </ul>	\$28.99
93788	Ambulatory Blood Pressure Monitoring with report-generating software – <ul style="list-style-type: none"> <li>Scanning analysis with report</li> </ul>	\$16.37
93790	Ambulatory Blood Pressure Monitoring with report-generating software – <ul style="list-style-type: none"> <li>Review with interpretation and report</li> </ul>	\$17.29
99473	Education and training on the set-up and use of Self-Measured Blood Pressure (SMBP) measurement device validated for clinical accuracy, and device calibration <ul style="list-style-type: none"> <li>Bill once per device</li> <li>E/M codes should not be reported with 99473, unless a significant, separately identifiable E/M service is completed. If an E/M service is reported using modifier 25, it must meet the criteria for a distinct E/M service with supported documentation.</li> </ul>	\$8.06
99474	SMBP data collection and interpretation of SMBP using a validated device - SMBP readings twice daily over a 30-day period (minimum of 12 readings) <ul style="list-style-type: none"> <li>Report of average systolic and diastolic pressures; communication and documentation of treatment plan</li> <li>Submit once per calendar month, cannot be used in the same calendar month as codes for ambulatory blood pressure monitoring (93784, 93786, 93788, 93790)</li> <li>E/M codes should not be reported with 99474, unless a significant, separately identifiable E/M service is completed. If an E/M service is reported using modifier 25, it must meet the criteria for a distinct E/M service with supported documentation.</li> </ul>	\$10.92

## Mental Health<sup>3,4,7-10</sup>

Initial primary care treatment and follow-up care are covered for members with mental health and/or substance abuse needs provided by a qualified provider. Wisconsin Medicaid will reimburse for E/M outpatient office visits (CPT procedure codes 99202–99205, 99211–99215, and HCPCS procedure code G2212) with an International Classification of Diseases (ICD) diagnosis code applicable to mental health and/or substance abuse services.

Since counseling may constitute a significant portion of the E/M services delivered to a member with mental health and/or substance abuse diagnoses, providers are required to fully document the percentage of the E/M time that involved counseling. This documentation is necessary to justify the level of E/M visit.<sup>8-10</sup>

CPT codes 90791 and 90792 are not separately reportable with individual, group, family, crisis, or other psychotherapy codes for the same date of service.<sup>3</sup>

E/M codes (e.g., 99202-99215) should not be reported with 90791 or 90792.<sup>4</sup>

For more information: [Forward Health Online Handbook - Topic #481: A Comprehensive Overview](#)

Billing Code	Description	Reimbursement Rate <sup>1</sup>
90791 <sup>#</sup>	Psychiatric diagnostic evaluation	\$72.03-155.80
90792 <sup>#</sup>	Psychiatric diagnostic evaluation with medical services	\$126.46-174.05
96127	Emotional/behavioral assessment (e.g., depression assessment, ADHD scale), with scoring and documentation, using standardized tool	\$3.59
H0033 <sup>†</sup>	Oral medication administration, direct observation	\$9.40

## Preventive Medicine<sup>7</sup>

- Services provided for the purpose of promoting health and reducing illness and injury
- Face-to-face time for new or established patients
- Risk factor reduction interventions: healthy diet, exercise, alcohol, and substance abuse
- CPT 99401 has been updated to add PT 23 (pharmacist). For 99402-99404, the system was built to allow the pharmacy/pharmacist billing/rendering provider combination, such that anytime PT 23 is the renderer and PT 24 is the biller, the claim will process.
- The Forward Health max fee schedule displays allowable rendering providers, which is why PT 24 is not displayed for CPT 99402-99404. When PT 24 is displayed as an allowable provider type, the pharmacy can bill for the service without submitting an additional rendering provider NPI on the claim for the claim to process.

Billing Code	Description	Reimbursement Rate <sup>1</sup>
<b>99401<sup>1</sup></b> (15 minutes)	Preventive medicine counseling and/or risk factor intervention(s) provided to patient	\$30.00
<b>99402<sup>1</sup></b> (Total 30 minutes)	Preventive medicine counseling and/or risk factor intervention(s) provided to patient	\$18.97
<b>99403<sup>1</sup></b> (Total 45 minutes)	Preventive medicine counseling and/or risk factor intervention(s) provided to patient	\$28.46
<b>99404<sup>1</sup></b> (Total 60 minutes)	Preventive medicine counseling and/or risk factor intervention(s) provided to patient	\$35.95
<b>99394<sup>#</sup></b>	Periodic comprehensive preventive medicine reevaluation and management – Age 12-17 years old <ul style="list-style-type: none"> <li>• Includes history, examination, counseling/anticipatory guidance/risk factor reduction interventions, ordering lab/diagnostic procedure for established patient.</li> </ul>	\$68.81
<b>99395<sup>#</sup></b>	Periodic comprehensive preventive medicine reevaluation and management – Age 18-39 years old <ul style="list-style-type: none"> <li>• Includes history, examination, counseling/anticipatory guidance/risk factor reduction interventions, ordering lab/diagnostic procedure for established patient.</li> </ul>	\$70.34
<b>99396<sup>#</sup></b>	Periodic comprehensive preventive medicine reevaluation and management – Age 40-64 years old <ul style="list-style-type: none"> <li>• Includes history, examination, counseling/anticipatory guidance/risk factor reduction interventions, ordering lab/diagnostic procedure for established patient.</li> </ul>	\$74.77
<b>99397<sup>#</sup></b>	Periodic comprehensive preventive medicine reevaluation and management – Age > 64 years old <ul style="list-style-type: none"> <li>• Includes history, examination, counseling/anticipatory guidance/risk factor reduction interventions, ordering lab/diagnostic procedure for established patient.</li> </ul>	\$80.61

## Pulmonary<sup>4,7</sup>

A provider should not report a separate E/M service if providing a limited physical examination during pulmonary diagnostic testing. If a significant, separately identifiable E/M service is performed unrelated to diagnostic testing, then an E/M service may be reported with **modifier 25**.<sup>4</sup>

Billing Code	Description	Reimbursement Rate <sup>1</sup>
94010	Baseline spirometry in office where there are no respiratory therapists <ul style="list-style-type: none"> <li>Spirometry – including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation.</li> </ul>	\$7.54-37.68
94014	Patient Recorded Spirometry per 30-day period <ul style="list-style-type: none"> <li>Includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration</li> <li>Includes review and interpretation by a physician or qualified health care professional</li> </ul>	\$40.96
94015	Patient Recorded Spirometry <ul style="list-style-type: none"> <li>Includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration</li> <li>Does not include review and interpretation by a physician or qualified health care professional</li> </ul>	\$25.84
94016	Patient Recorded Spirometry <ul style="list-style-type: none"> <li>Review and interpretation by physician or qualified health care professional</li> </ul>	\$15.13
94060	Providing spirometry in office where there are no respiratory therapists following administration of bronchodilator to determine asthma obstruction and COPD obstruction.	\$12.59-47.47
94640 (<1 hour)	Pressurized or non-pressurized inhalation treatment for acute airway obstruction for therapeutic or diagnostic purposes (e.g., sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device). (Services less than 1 hour) <ul style="list-style-type: none"> <li>Should only be reported once during an episode of care regardless of the number of separate inhalation treatments administered.<sup>2</sup></li> <li>If used for treatment, spirometry measurements should not be reported separately.</li> <li>If inhalation drugs are used in a continuous treatment exceeding 1 hour, CPT code 94644 may be reported instead.<sup>2</sup></li> <li>CPT code 94640 and 94664 should not be reported for the same patient encounter.<sup>2</sup></li> </ul>	\$10.73
94642	Aerosol Inhalation Treatment	\$110.09
94644 (1 hour)	Continuous inhalation treatment with aerosol medication for acute airway obstruction.	\$25.38
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device (Can only be used once per day). <ul style="list-style-type: none"> <li>If inhalation drugs are used in a continuous treatment exceeding 1 hour, CPT code 94644 should be reported.<sup>2</sup></li> <li>CPT code 94640 and 94664 should not be reported for the same patient encounter.<sup>2</sup></li> </ul>	\$15.29

# INFUSIONS & INJECTABLES

## Infusion & Non-Vaccine Injectable Medications<sup>2,4,7,12,13</sup>

### Non-Vaccine Injectable (NVI) Medications

Buy and bill product as PHARMACIST provider → Use J-code to bill [Provider Administered Drug](#) to Fee For Service (FFS) Medicaid.

- HMO Patient: Bill associated product administration, office visit (if applicable), etc. to HMO\*
- FFS Patient: Bill associated product administration, office visit (if applicable), etc. to FFS Medicaid

Buy and bill product as PHARMACY provider → Bill using national drug code (NDC) to Medicaid pharmacy benefit (Standard adjudication)

- HMO Patient: Bill associated product administration, office visit (if applicable), etc. to HMO\*
- FFS Patient: Bill associated product administration, office visit (if applicable), etc. to FFS Medicaid\*

\*Attach J code to claim with \$0 (or \$0.01) so that the service codes are recognized

- J code reimbursement is listed as per unit of medication
- [Physician-administered Drug Claim Requirements](#)<sup>12</sup>

[Provider Administered Drugs](#) (Medicaid Handbook #5697) includes the list of provider administered drugs required to be billed to FFS Medicaid.<sup>13</sup>

### Obtaining Physician-Administered Drugs

To ensure the content and integrity of the drugs administered to members, prescribers are required to obtain all drugs that will be administered in their offices. Prescribers may obtain a physician-administered drug from a pharmacy provider if the drug is delivered directly from the pharmacy to the prescriber's office. Prescribers may also obtain a drug to be administered in the prescriber's office from a drug wholesaler or direct purchase. Pharmacy providers should not dispense a drug to a member if the drug will be administered in the prescriber's office.<sup>12-13</sup>

### Chemotherapy

When chemotherapy for a malignant disease is provided in a provider's office, separate reimbursement is allowed for the following:

- E/M visits
- The drug, including injection of the drug
- Therapeutic infusions
- Supplies
- Physician-administered oral anti-emetic drugs

Use procedure code 99070 for supplies and materials provided by the provider.

Chemotherapy drugs (HCPCS codes J9000-J9999) are covered. Reimbursement for these procedure codes includes the cost of the drug and the charge for administering the drug.<sup>12-13</sup>

**CPT codes 96360-96379:** Outpatient hospital facility – administration of fluids and drugs during, or for an operative procedure, are included in services and are not separately reportable.<sup>2</sup>

**CPT codes 96360, 96365, 96374, 96409, 96413:** “Initial” service codes. Only one “initial” service code may be reported unless medically necessary for the administration to occur at a separate intravenous access site.<sup>+</sup>

**CPT codes 96360-96379, 96401-96425, and 96521-96523:** Reportable by a provider when performed in providers' offices. These services must not be reported if administered by a provider in a facility setting such as a hospital outpatient department or emergency department.<sup>4</sup>

Hospital outpatient facilities may report drug administration services (e.g., CPT codes 96360-96379) and chemotherapy administration services (e.g., CPT codes 96401-96425) with facility-based E/M codes (e.g., 99281-99285) if the E/M service is significant and separate. **Modifier 25** must be used in these circumstances.<sup>4</sup>

HCPCS/CPT codes 96360-96375, 96377 and 96401-96425 include services within 99211. CPT code 99211 should not be reported. Other non-facility-based E/M CPT codes (e.g., 99202-99205, 99212-99215) can be reported separately with **modifier 25** if a separately identifiable service is performed.<sup>4</sup>

Providers should not report drug administration services in a facility setting; therefore, a facility-based E/M CPT code (e.g., 99281-99285) should not be reported unless service is performed at a separate encounter in a non-facility setting on the same date of service.<sup>4</sup>

Outpatient hospital facilities may report drug administration services and facility-based E/M codes (e.g., 99281-99285) if the E/M service is separately identifiable with addition of **modifier 25**.<sup>4</sup>

Billing Code	Description	Reimbursement Rate <sup>1</sup>
<b>Intravenous Infusion</b>		
<b>96360</b> (31 minutes to 1 hour)	Initial	\$50.58
<b>+96361</b> (each additional hour)	Each additional hour (List separately in addition to code for primary procedure)	\$16.07
<b>96365</b> (up to 1 hour)	For therapy, prophylaxis, or diagnosis (specify product or drug) – Initial	\$61.86
<b>+96366</b> (each additional hour)	For therapy, prophylaxis, or diagnosis (specify product or drug) (List separately in addition to code for primary procedure)	\$20.85
<b>+96367</b> (up to 1 hour)	For therapy, prophylaxis, or diagnosis (specify product or drug); additional sequential infusion of new drug/product (List separately in addition to code for primary procedure)	\$34.15
<b>+96368</b>	For therapy, prophylaxis, or diagnosis (specify product or drug); concurrent infusion (List separately in addition to code for primary procedure)	\$19.92
<b>Subcutaneous Infusion</b>		
<b>96369</b> (≤ 15 minutes)	For therapy or prophylaxis (specify product or drug) – Initial <ul style="list-style-type: none"> <li>Including pump set-up and establishment of subcutaneous infusion site(s)</li> </ul>	\$123.61
<b>+96370</b> (each additional hour)	For therapy or prophylaxis (specify product or drug) (List separately in addition to code for primary procedure)	\$11.89
<b>+96371</b>	For therapy or prophylaxis (specify product or drug) <ul style="list-style-type: none"> <li>Additional pump set-up with establishment of new subcutaneous infusion site(s)</li> </ul> (List separately in addition to code for primary procedure)	\$53.18

Billing Code	Description	Reimbursement Rate <sup>1</sup>
<b>Injection</b>		
96372	Subcutaneous or intramuscular - Therapeutic, prophylactic, or diagnostic injection (specify product or drug)	\$3.31
96373	Intra-arterial - Therapeutic, prophylactic, or diagnostic injection (specify product or drug)	\$15.78
96374 (single or initial)	Intravenous push, single or initial drug/product - Therapeutic, prophylactic, or diagnostic injection (specify product or drug)	\$46.21
*96375 (each additional)	Each additional intravenous push of a new drug/product - Therapeutic, prophylactic, or diagnostic injection (specify product or drug) (List separately in addition to code for primary procedure)	\$21.52
*96376 (each additional)	Each additional sequential intravenous push of the same drug/product - Therapeutic, prophylactic, or diagnostic injection (specify product or drug) (List separately in addition to code for primary procedure)	\$21.75
<b>Chemotherapy Administration</b>		
96401	Subcutaneous or intramuscular - non-hormonal anti-neoplastic	\$53.36
96402	Subcutaneous or intramuscular – hormonal anti-neoplastic	\$28.86
96409 (single or initial)	Intravenous push – single or initial product/drug	\$97.90
*96411 (each additional)	Intravenous push – each additional product/drug (List separately in addition to code for primary procedure)	\$56.74
96413 (up to 1 hour)	Intravenous infusion – single or initial product/drug	\$135.18
*96415 (each additional hour)	Intravenous infusion – each additional product/drug (List separately in addition to code for primary procedure)	\$30.14
96416 (more than 8 hours)	Prolonged intravenous infusion (more than 8 hours) Requiring use of a portable or implantable pump	\$148.15
*96417 (up to 1 hour)	Intravenous infusion – each additional sequential infusion (different product/ drug) (List separately in addition to code for primary procedure)	\$67.59
96420	Intra-arterial push	\$25.55
96422 (up to 1 hour)	Intra-arterial infusion	\$25.55
*96423 (each additional hour)	Intra-arterial infusion – each additional hour (List separately in addition to code for primary procedure)	\$25.55
96425 (more than 8 hours)	Prolonged intra-arterial infusion (more than 8 hours) Requiring the use of a portable or implantable pump	\$25.55
96440	Administration into pleural cavity, requiring and including thoracentesis	\$118.50
96446	Administration into peritoneal cavity using indwelling port or catheter	\$13.37
96521	Refilling and maintenance of portable pump	\$122.28
96522	Refilling and maintenance of portable pump or reservoir for systemic drug delivery (e.g., intravenous, intra-arterial)	\$88.47
96523	Irrigation of implanted venous access device for drug delivery systems	\$22.41
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir (single or multiple agents)	\$89.58

Billing Code	Description	Reimbursement Rate <sup>1</sup>
<b>Injection (not an all-inclusive list)</b>		
J0401*	Aripiprazole, extended release, 1 mg	\$6.81
J0402*	Aripiprazole (ABILIFY ASIMTUFI <sup>®</sup> ), 1 mg	\$5.81
J0517*	Benralizumab, 1 mg	\$165.25
J0592	Buprenorphine hydrochloride, 0.1 mg	\$4.30
Q9991	Buprenorphine extended release (SUBLOCADE <sup>®</sup> ), ≤ 100 mg	\$8.70
Q9992	Buprenorphine extended release (SUBLOCADE <sup>®</sup> ), > 100 mg	\$8.70
J0696*	Ceftriaxone sodium, per 250 mg	\$0.45
J0897*	Denosumab	\$25.19
J1050#.*	Medroxyprogesterone acetate, 1 mg	\$0.57
J1071*	Testosterone cypionate, 1 mg	\$0.01
J1306%	Inclisiran, 1 mg	\$12.12
J1630	Haloperidol	\$1.16
J1631*	Haloperidol decanoate, per 50 mg	\$6.53
J1650*	Enoxaparin sodium, 10 mg	\$0.62
J1652*	Fondaparinux Sodium	\$1.03
J1943	Aripiprazole lauroxil (ARISTADA INITIO <sup>®</sup> ), 1 mg	\$3.14
J1944*	Aripiprazole lauroxil 1 mg	\$3.22
J2182*	Mepolizumab, 1 mg	\$30.48
J2310	Naloxone hydrochloride, per 1 mg	\$8.70
J2315 <sup>†,*,%</sup>	Naltrexone, depot form, 1 mg	\$3.97
J2357*	Omalizumab	\$36.81
J2358*	Olanzapine, long-acting, 1 mg	\$2.92
J2426*	Paliperidone palmitate, extended release (INVEGA SUSTENNA <sup>®</sup> ), 1 mg	\$14.28
J2679*	Fluphenazine HCl, 1.25 mg	\$7.89
J2680	Fluphenazine decanoate 25 mg	\$8.92
J2786*	Reslizumab, 1 mg	\$10.23
J2794*	Risperidone (RISPERDAL CONSTA <sup>®</sup> ), 0.5 mg	\$12.18
J2799*	Risperidone (UZEDY <sup>™</sup> ), 1 mg	\$24.41
J2801	Risperidone (RYKINDO <sup>®</sup> ), 0.5 mg	\$105.00
J3420*	Vitamin B-12 cyanocobalamin, up to 1000 mcg	\$1.42

# OTHER TIME-BASED E/M SERVICES

## Digitally Stored Data Services/Remote Physiological Monitoring<sup>7</sup>

- Must be an FDA-approved medical device (e.g., self-monitored blood pressure monitor, pulse oximeter, etc.)
- Must have an order for the service from physician or other qualified health care professional

Billing Code	Description	Reimbursement Rate <sup>1</sup>
<b>99091</b> (30 minutes)	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and sent by patient/caregiver to physician or qualified professional	\$42.62
<b>99453</b>	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate) – Initial <ul style="list-style-type: none"> <li>• Includes set-up and education on use of equipment</li> </ul>	\$13.52
<b>99454</b>	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate) – Initial <ul style="list-style-type: none"> <li>• Device(s) provide daily recordings or programmed alert transmission</li> <li>• Bill only once per month</li> </ul>	\$46.40
<b>99457</b> (first 20 minutes)	Remote physiologic monitoring treatment management services <ul style="list-style-type: none"> <li>• Bill based on time spent in interactive communication with patient/caregiver</li> </ul>	\$37.16
<b>+99458</b> (each additional 20 minutes)	Remote physiologic monitoring treatment management services <ul style="list-style-type: none"> <li>• Bill based on time spent in interactive communication with patient/caregiver</li> </ul> (List separately in addition to code for primary procedure)	\$30.40
<b>99473</b>	Self-measured blood pressure using validated device <ul style="list-style-type: none"> <li>• Includes patient education/training and device calibration</li> <li>• Refer to the Hypertension section for more information</li> </ul>	\$8.06
<b>99474</b>	Self-measured blood pressure using validated device <ul style="list-style-type: none"> <li>• Includes patient education/training and device calibration</li> <li>• Two separate self-measured readings, one minute apart, twice daily over a 30-day period (minimum of 12 readings)</li> <li>• Report of average systolic and diastolic pressures with treatment plan communicated to patient</li> <li>• Refer to the Hypertension section for more information</li> </ul>	\$10.92

## Online Digital Evaluation and Management Services<sup>7</sup>

- Service for patient-initiated communication using a HIPAA-compliant secure platform for established patient
- 7-day period begins with initial review of patient-initiated inquiry
- Cumulative service time over 7-day period includes:
  - » Review of initial inquiry
  - » Review of patient records or data pertinent to patient’s assessment
  - » Interaction with medical team focused on patient’s problem
  - » Development of management plan, including ordering prescriptions and labs/tests
  - » Subsequent communication with patient via online, telephone, email or other digitally supported communication

For more information, reference: [Forward Health Online Handbook - Topic 22742: Virtual Check-In, E-Visit, and Telephone Evaluation and Management Services](#)

Billing Code	Description	Reimbursement Rate <sup>1</sup>
<b>Physician or Other Qualified Health Care Professional</b>		
<b>99421</b> (5-10 minutes)	Online digital evaluation and management service for established patient, for up to 7 days	\$10.53
<b>99422</b> (11-20 minutes)	Online digital evaluation and management service for established patient, for up to 7 days	\$20.93
<b>99423</b> (≥21 minutes)	Online digital evaluation and management service for established patient, for up to 7 days	\$33.82

## PREVENTIVE CARE SERVICES

### Alcohol and Substance Dependency

Billing Code	Description	Reimbursement Rate <sup>1</sup>
<b>96160</b>	Health Behavior Assessment/Intervention Services	\$4.01
<b>H0004<sup>#,1</sup></b> (per 15 minutes)	Behavioral health counseling and therapy	\$18.21
<b>H0005<sup>1</sup></b>	Alcohol/Drug Services; Group Counseling by a clinician	\$3.82-5.08
<b>H0020<sup>1</sup></b>	Methadone administration and/or service (provision of drug by a licensed program)	\$85.65
<b>H0022<sup>1</sup></b>	Alcohol and/or drug intervention service (planned facilitation)	\$18.92-44.41
<b>H0047<sup>1</sup></b>	Alcohol and/or other drug abuse services, not otherwise specified	\$25.22 – 44.41
<b>H0049<sup>#,1</sup></b>	Alcohol and/or other drug screening	\$35.35
<b>H0050<sup>#,1</sup></b> (per 15 minutes)	Alcohol and/or drug services, brief intervention, per 15 minutes	\$18.21

## Immunizations<sup>7,12,14,15</sup>

- **Vaccine Services Provided in Pharmacy:** Forward Health reimburses vaccine services provided in a pharmacy on a fee-for-service basis for adult members (19 years and older) even if they are enrolled in a state-contracted Health Maintenance Organization (HMO) or managed care organization (MCO).
- Forward Health reimburses pharmacy providers the cost of the vaccine and the administration when the CPT procedure code for the vaccine is reported on the claim. Claims submitted with National Drug Codes (NDCs) for vaccine services will be denied.<sup>12</sup>
- Pharmacies should not use the general administration CPT code for vaccine services. Reimbursement for both the vaccine and the administration are included in the specific vaccine procedure code. Pharmacy providers should not separately bill for vaccine administration. Providers are required to indicate their usual and customary charge for the service with the procedure code.
- If a patient encounter occurs in addition to the administration of the injection, providers may receive reimbursement for the appropriate E/M procedure code that reflects the level of service provided at the time of the vaccination.
- If an immunization is the only service provided, the lowest level E/M office or outpatient service procedure code may be reimbursed, in addition to the appropriate vaccine procedure code(s).<sup>14-15</sup>
- For more information:
  - » [Forward Health Online Handbook - Topic #12457: Vaccines](#)
  - » [Forward Health Online Handbook - Topic #503: Immunizations](#)
  - » [Forward Health Update 2023-49 - Expanded Vaccine Coverage for Members in BadgerCare Plus and Wisconsin Medicaid](#)
  - » [Forward Health Update June 2024 - Coverage Policy for Medicaid-Enrolled Pharmacists](#)
  - » [CMS Medicaid and CHIP Coverage of Stand-alone Vaccine Counseling](#)

Billing Code	Description	Reimbursement Rate <sup>1</sup>
<b>G0311</b> (16-30 min)	Immunization counseling when the vaccine(s) is not administered on the same date of service	\$33.26
<b>G0312</b> (5-15 min)	Immunization counseling when the vaccine(s) is not administered on the same date of service for ages under 21 years	\$14.46
<b>G0313</b> (16-30 min)	Immunization counseling when the vaccine(s) is not administered on the same date of service for ages under 21 years	\$33.26
<b>G0314</b> (16-30 min)	Immunization counseling for COVID-19 for ages under 21 years	\$33.26
<b>G0315</b> (5-15 min)	Immunization counseling for COVID-19 for ages under 21 years	\$14.46
<b>M0201</b> #	Administration of Pneumococcal, Influenza, Hepatitis B, and/or COVID-19 vaccine inside a patient's home. Patients age > 64 years. <ul style="list-style-type: none"> <li>• Reported only once per individual home per date of service when administered at the patient's home</li> </ul>	\$38.16
<b>90611</b> #	SMALLPOX & MONKEYPOX VAC 0.5ML	\$285.00
<b>90636</b> #	HEP A/HEP B VACC ADULT - IM	\$138.40
<b>90649</b> #	HUMAN PAPILLOMAVIRUS - 4VHPV TYPES 6, 11, 16, 18, QUADRIVALENT VACCINE -3 DOSE - IM	\$175.17
<b>90650</b> #	HUMAN PAPILLOMAVIRUS - 2VHPV TYPES 16, 18, BIVALENT VACCINE - 3 DOSE - IM	\$143.75
<b>90651</b> #	HUMAN PAPILLOMAVIRUS - 9VHPV TYPES 6, 11, 16, 18, 31, 33, 45, 52, 58 VACCINE 2/3 DOSE - IM	\$283.77
<b>90656</b> #	INFLUENZA - TRIVALENT, PRESERVATIVE-FREE	\$15.00- 35.79

Billing Code	Description	Reimbursement Rate <sup>1</sup>
90662 <sup>#</sup>	INFLUENZA HIGH-DOSE	\$88.40
90671 <sup>#</sup>	PNEUMOCOCCAL CONJUGATE - PCV15 VACCINE - IM	\$230.34
90677 <sup>#</sup>	PNEUMOCOCCAL CONJUGATE - PCV20 VACCINE - IM	\$268.21
90707 <sup>#</sup>	MMR VACCINE - SUBQ	\$104.87
90713 <sup>#</sup>	POLIOVIRUS IPV - SUBQ/IM	\$55.64
90715 <sup>#</sup>	TDAP VACCINE 7 YRS/> - IM	\$67.41
90716 <sup>#</sup>	VARICELLA VACCINE LIVE - SUBQ	\$174.24
90723 <sup>#</sup>	DTAP-HEP B-IPV VACCINE - IM	\$15.00
90732 <sup>#</sup>	PNEUMOCOCCAL POLYSACCHARIDE - PPSV23 VACCINE - 2 YRS+ - SUBQ/IM	\$132.08
90739 <sup>#</sup>	HEP B VACCINE 2/4 DOSE ADULT IM	\$155.60
90746 <sup>#</sup>	HEP B VACCINE 3 DOSE ADULT IM	\$81.85
91304 <sup>#</sup>	SARS-COV2 VACCINE 5MCG/0.5ML IM	\$148.20

## Laboratory<sup>16,17</sup>

### [Forward Health Online Handbook - Topic #899: CLIA Certification or Waiver](#)

- Pharmacists may perform Clinical Laboratory Improvement Amendments (CLIA)-waived testing, but the entity where they are employed will need to hold CLIA certification and be enrolled in Forward Health as an Independent Lab in order to bill and receive reimbursement for testing.<sup>16</sup>
- The Independent Lab must also be certified to participate in Medicare according to [DHS.105.43](#).

### **CLIA-Waived:** Tests simple to perform and carry low risk of an incorrect result.

- Sites that perform waived testing must have a CLIA certificate and follow manufacturer instructions (other CLIA requirements do not apply to these sites).
- A CLIA certificate must be issued to a laboratory in order to perform only CLIA-waived tests
- Examples: urine pregnancy tests, rapid strep tests, urine chemistry dipstick, glucometers, INR, etc.<sup>17</sup>

### **Steps to Enroll as an Independent Physician Lab:**

1. Apply and become a certified CLIA provider: [CLIA Application and Fee Payment](#)
2. Enroll as an Independent Lab (*similar to Medicaid Provider Enrollment, but enrolling as a lab*): [CLIA Lab Enrollment Application](#)
  - a. Select 'Start or Continue Your Enrollment Application' in the upper right corner
  - b. Under 'To Start a New Medicaid Enrollment', select 'Medicaid/Border Status Provider Enrollment Application'
  - c. Click 'Next' to begin application
  - d. Type of Applicant: Choose 'Organization'

Pharmacies and labs must have a CLIA waiver to perform CLIA-waived tests. CPT billing codes for COVID, Strep, RSV, Influenza, PrEP and other CLIA-waived tests may be specific to the brand or type of test being used. Please refer to the CPT billing codes recommended by the specific test manufacturer. Refer to [CDC Waived Status Table](#) for a list of CLIA-waived test CPT codes.<sup>18</sup>

Patients being referred to a laboratory for monitoring will be charged for the test administration by the laboratory.

Consult with an experienced coding professional to determine appropriate code selection. Review the [Max Fee Dynamic Search \(wi.gov\)](#) for more information.

### Tobacco Cessation<sup>5,7</sup>

- Must be performed one-on-one, face-to-face for new and established patients
- Preventive Code: Risk factor reduction interventions (e.g., healthy diet, exercise, alcohol, and substance abuse)
- Prescribing tobacco cessation agents requires an appropriate diagnosis on the prescription
- 99406 and 99407 can be billed for tobacco cessation consultation services under pharmacist scope of practice. For more information: [Tobacco Cessation Drugs and Services](#).<sup>19</sup>

Billing Code	Description	Reimbursement Rate <sup>1</sup>
<b>99406</b> (3-10 minutes)	Smoking and tobacco use cessation counseling; intermediate	\$10.18
<b>99407</b> (>10 minutes)	Smoking and tobacco use cessation counseling; intensive	\$18.99

# REFERENCES

1. Wisconsin Department of Health Services. Forward Health Max Fee Schedule. <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeDynamicSearch.aspx>. Accessed 9/30/24.
2. Centers for Medicare & Medicaid Services. Medicaid NCCI Policy Manual Chapter 1: General Coding Policies. <https://www.cms.gov/files/document/medicaid-ncci-policy-manual-2024-chapter-1.pdf>. Updated 1/1/2024. Accessed. 8/1/2024.
3. Centers for Medicare & Medicaid Services. Medicare Learning Network Booklet. Evaluation and Management Services Guides. August 2023. <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf>. Accessed 8/15/2024.
4. Centers for Medicare & Medicaid Services. Medicaid NCCI Policy Manual Chapter 11: Medicine Evaluation and Management Services CPT Codes 90000-99999. <https://www.cms.gov/files/document/medicaid-ncci-policy-manual-2024-chapter-11.pdf>. Updated 1/1/2024. Accessed 8/1/2024.
5. Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual Chapter 12 – Physicians/Nonphysician Practitioners. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>. Accessed 9/25/24.
6. Wisconsin Department of Health Services. Forward Health Update 2024-17 – Coverage Policy for Medicaid-Enrolled Pharmacists. <https://www.forwardhealth.wi.gov/kw/pdf/2024-17.pdf>. Accessed 9/30/24.
7. Arnold J, Ramsey S, Zhang B. Pharmacy Practice Guidebook: Medical Billing, Coding, and Documentation for Pharmacy Professionals. American Medical Association: 2022. Washington State Pharmacy Association: 2023.
8. Centers for Medicare & Medicaid Services. Medicaid NCCI Policy Manual Chapter 11: Medicine Evaluation and Management Services CPT Codes 90000-99999. <https://www.cms.gov/files/document/medicaid-ncci-policy-manual-2024-chapter-11.pdf>. Updated 1/1/2024. Accessed 8/1/2024.
9. Wisconsin Department of Health Services. Forward Health Online Provider Handbook - Covered and Noncovered Services: Evaluation and Management. <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=50&s=2&c=101>. Accessed 8/1/2024.
10. Wisconsin Department of Health Services. Forward Health Online Provider Handbook - Covered and Noncovered Services: Covered Services and Requirements – Continuous Glucose Monitoring. <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=50&s=2&c=61&nt=Continuous+Glucose+Monitoring>. Accessed 8/1/2024.
11. Kronish IM, Hughes C, Quispe K, Viera AJ. Implementing Ambulatory Blood Pressure Monitoring in Primary Care Practice. *Fam Pract Manag.* 2020 May/June;27(3):19-25.
12. Wisconsin Department of Health Services. Forward Health Online Provider Handbook - Covered and Noncovered Services: Covered Services and Requirements – Physician-Administered Drug Claim Requirements. <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=50&s=4&c=13&nt=Physician-Administered+Drug+Claim+Requirements&adv=Y>. Accessed 8/15/2024.
13. Wisconsin Department of Health Services. Forward Health Online Provider Handbook - Covered and Noncovered Services: Covered Services and Requirements – Physician-Administered Drugs. <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=50&s=2&c=61&nt=Physician-Administered+Drugs>. Accessed 8/1/2024.
14. Wisconsin Department of Health Services. Forward Health Update 2023-49 – Expanded Vaccine Coverage for Members in BadgerCare Plus and Wisconsin Medicaid. <https://www.forwardhealth.wi.gov/kw/pdf/2023-49.pdf>. Accessed 8/15/2024.
15. Wisconsin Department of Health Services. Forward Health Online Provider Handbook - Covered and Noncovered Services: Covered Services and Requirements – Immunizations. <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=50&s=2&c=61&nt=Immunizations>. Accessed 8/1/2024.
16. Wisconsin Department of Health Services. Forward Health Online Provider Handbook – Provider Enrollment and Ongoing Responsibilities: Provider Enrollment – CLIA Certification or Waiver. <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=85&s=1&c=1&nt=CLIA+Certification+or+Waiver&adv=Y>. Accessed 8/1/2024.
17. Centers for Disease Control and Prevention. Clinical Laboratory Improvement Amendments (CLIA): Test Complexities. Centers for Disease Control and Prevention. <https://www.cdc.gov/clia/test-complexities.html>. Accessed 8/1/2024.
18. U.S. Centers for Disease Control and Prevention. Tests Granted Waived Status Under CLIA. <https://www.cdc.gov/clia/docs/tests-granted-waived-status-under-clia.pdf>. Accessed. 2/4/2025.
19. Wisconsin Department of Health Services. Forward Health Online Provider Handbook - Covered and Noncovered Services: Covered Services and Requirements – Tobacco Cessation Drugs and Services. <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=50&s=2&c=61&nt=Tobacco+Cessation+Drugs+and+Services>. Accessed 1/24/2025.
20. American Medical Association. 2023 CPT E&M Inpatient & Outpatient Level of Medical Decision Making (MDM). <https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf>. Accessed 9/12/2024.

# APPENDIX A: CPT E/M LEVEL OF MEDICAL DECISION MAKING (MDM)<sup>20</sup>

Level of MDM	Number & Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed & Analyzed	Risk of Complications and/or Morbidity/Mortality of Patient Management
<b>STRAIGHTFORWARD</b> 99202/99212+ (15-29 min/10-19 min)  99341/99347+ (15 min/20 min)	<b>Minimal</b> <ul style="list-style-type: none"> <li>• 1 Self-limited or minor problem</li> </ul>	<b>Minimal or none</b>	<b>Minimal risk</b> of morbidity from additional diagnostic testing or treatment
<b>LOW</b> 99203/99213+ (30-44 min/20-29 min)  99342/99348+ (30 min/30 min)	<b>Low</b> <ul style="list-style-type: none"> <li>• 2 or more self-limited or minor problems</li> <li>• 1 stable chronic illness</li> <li>• 1 acute, uncomplicated illness or injury</li> <li>• 1 stable, acute illness</li> <li>• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care</li> </ul>	<b>Limited (at least 1 of these categories):</b>  <b>Category 1:</b> Tests and documents: ≥2 of the following: <ul style="list-style-type: none"> <li>• Review of prior external notes</li> <li>• Review of results of each unique test</li> <li>• Ordering of each unique test</li> </ul> <b>Category 2:</b> Assessment requiring an independent historian	<b>Low risk</b> of morbidity from additional diagnostic testing or treatment
<b>MODERATE</b> 99204/99214+ (45-59 min/30-39 min)  99344/99349+ (60 min/40 min)	<b>Moderate</b> <ul style="list-style-type: none"> <li>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment</li> <li>• 2 or more stable chronic illnesses</li> <li>• 1 undiagnosed new problem with uncertain prognosis</li> <li>• 1 acute illness with systemic symptoms</li> <li>• 1 acute complicated injury</li> </ul>	<b>Moderate (at least 1 of these categories):</b>  <b>Category 1:</b> Tests, documents or independent historian(s): ≥3 of the following: <ul style="list-style-type: none"> <li>• Review of prior external notes</li> <li>• Review of results of each unique test</li> <li>• Ordering of each unique test</li> <li>• Assessment requiring an independent historian</li> </ul> <b>Category 2:</b> Independent interpretation of a test by another provider (not reported separately)  <b>Category 3:</b> Discussion of management or test interpretation with another provider (not reported separately)	<b>Moderate risk</b> of morbidity from additional diagnostic testing or treatment  <i>Examples only:</i> <ul style="list-style-type: none"> <li>• Prescription drug management</li> <li>• Decision regarding minor surgery with identified patient or procedure risk factors</li> <li>• Decision regarding elective major surgery without identified patient or procedure risk factors</li> <li>• Diagnosis or treatment significantly limited by social determinants of health</li> </ul>
<b>HIGH</b> 99205/99215+ (60-74 min/40-54 min)  99345/99350+ (75 min/60 min)	<b>High</b> <ul style="list-style-type: none"> <li>• 1 or more chronic illnesses with severe exacerbation, progression or side effects of treatment</li> <li>• 1 acute or chronic illness or injury that poses a threat to life or bodily function</li> </ul>	<b>Extensive (at least 2 of these categories):</b>  <b>Category 1:</b> Tests and documents, or independent historian(s): ≥3 of the following: <ul style="list-style-type: none"> <li>• Review of prior external notes</li> <li>• Review of results of each unique test</li> <li>• Ordering of each unique test</li> <li>• Assessment requiring an independent historian</li> </ul> <b>Category 2:</b> Independent interpretation of a test by another provider (not reported separately)  <b>Category 3:</b> Discussion of management or test interpretation with another provider (not reported separately)	<b>High risk</b> of morbidity from additional diagnostic testing or treatment:  <i>Examples only:</i> <ul style="list-style-type: none"> <li>• Drug therapy requiring intensive monitoring for toxicity</li> <li>• Decision regarding elective major surgery with identified patient or procedure risk factors</li> <li>• Decision regarding emergency major surgery</li> <li>• Decision regarding hospitalization or escalation of hospital-level of care</li> <li>• Decision not to resuscitate or to de-escalate care because of poor prognosis</li> </ul>

+99202-99205; 99341-99345: New Patients  
 99212-99215; 99347-99350: Established Patients