Pharmacist Billing/Coding Quick Reference Sheet
For Services Provided in Physician-Based Clinics
Date of Publication: June 2019 (updated from June 2016 FAQ)

"Incident-to" billing CPT Codes

- Since pharmacists do not currently have provider status, CPT codes higher than Level 1 are not routinely allowed by most payers. However, depending on state scope of practice or the specific payer, these ***may*** be available.
- Higher levels indicate higher encounter complexity.
- Each level above 99211 has certain requirements for documentation elements.

Level of Service: E/M Overview

Level	History	Physical Exam	Med Decision Making	Time	Estimated Reimbursement
99211 (Level 1) Minimal	Minimal	Minimal	None	5 minutes	$23.07
99212 (Level 2) Problem Focused	CC, HPI	1-5 Elements	Straightforward	10 minutes	$45.77
99213 (Level 3) Expanded Problem Focused	CC, HPI, ROS	6 or more elements	Low Complexity	15 minutes	$75.32
99214 (Level 4) Detailed	CC, HPI, ROS, PFSH	12 elements	Moderate Complexity	25 minutes	$110.28
99215 (Level 5) Comprehensive	CC, HPI, ROS, PFSH	All elements	High Complexity	40 minutes	$147.76

E/M= evaluation and management; CC = chief complaint; HPI = history of present illness;
ROS = review of systems; PFSH = past medical, family or social hx
Resource: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf
Resource: www.cms.gov/apps/physician-fee-schedule

Level of Service: Medical Decision Making Overview

Level	Diagnosis/Management Options	Amount/Complexity of Data	Risk of Complication, Morbidity or Mortality
99212 (Straightforward)	Minimal	Minimal or None	Minimal
99213 (Low Complexity)	Limited	Limited	Low
99214 (Moderate Complexity)	Multiple	Moderate	Moderate
99215 (High Complexity)	Extensive	Extensive	High

Resource: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

MTM CPT Codes

- Must be face-to-face and include review of pertinent patient history, not just drug history, and recommendations to improve medication outcomes and patient compliance.
- Only billable currently through MTM contract with Medicare Prescription Drug plan.
- Reimbursement is set by Part D sponsor.

Code	Services and time	Patient Type
99605	MTM services provided by pharmacist; Initial 15 minutes	New patient
99606	MTM services provided by pharmacist; Initial 15 minutes	Established patient
99607	MTM services provided by pharmacist; Each additional 15 minutes (listed separately and in conjunction with 99605 and 99607)	Established patient

Resource: www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html

Education specific CPT codes (Education and Training for Self-Management)

- Not paid by Medicare, but ***may*** be paid by private payers.
- If for DM Education, these codes do not require a DSMT program to be recognized.
- Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with patient (could include caregiver/family).

Code	Time Spent	Number of patients
98960	Each 30 minutes	Individual patient
98961		2-4 patients
98962		5-8 patients

Resource: American Medical Association. 2019. CPT 2019 Professional Edition. American Medical Association.

Diabetes Self-Management Training/ Education (DSMT/E)

- G Codes can be used for DSMT/E if the program is recognized by ADA or AADE **and** if the pharmacist is a Certified Diabetes Educator (CDE).
- For the individual DSMT/E sessions, Medicare covers 10 hours of education the first year and 2 hours each subsequent year. Of these hours, 1 can be provided as an individual session and the other 9 or 1 (depending on year) must be in a group setting. The program must offer group classes, but if there is no availability within 2 months, an individual session may be approved. Other criteria that qualify for additional individual sessions include: additional insulin training, hearing impairment, visual impairment, physician impairment, or language barrier.
- The counseling services provided as part of this education can count as a component of E&M services (99212-99215).
- Comprehensive diabetes self-management education may include: balancing nutrition and physical activity, maintaining glycemic control, and performing self-care tasks (i.e. blood glucose monitoring and insulin administration).

Code	Description of Service	Estimated Reimbursement
G0108	Used for each 30 min of an individual DSMT/E session	$56.22
G0109	Used for each 30 min of a group (2 to 20 persons)	$15.50/patient

Note: FQHCs with an accredited program can bill for DSMT or MNT services. However, only individual services qualify as a separate encounter, so they are able to be billed. Group services do not qualify as billable encounters.

Resource: For complete information, refer to CMS Benefit Policy Manual: Chapter 15, Section 300.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-Ioms-Items/Cms012673.html
https://www.myaadenetwork.org/p/bl/et/blogid=160&blogaid=2178

Medicare Annual Wellness Visits (AWV)

- Important to note that pharmacists ***cannot*** bill Welcome to Medicare (IPPE) Visit (G0402) as this must be completed by physician in the first year of enrollment.

Code	Description of Service	Estimated Reimbursement*
G0438	First Annual Wellness Visit	$174.43
G0439	Subsequent Annual Wellness Visits	$118.21

Note: Billing will differ in FQHC settings, where pharmacists cannot bill directly for these visits. The physician provider must bill for the service after having face to face contact with the patient.

Resource: For complete information, refer to CMS Benefit Policy Manual: Chapter 15, Section 280.5.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
Resource:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-_MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf
*Resource:
www.cms.gov/apps/physician-fee-schedule

Chronic Care Management Services (CCM)

- Pharmacists ***cannot*** bill, but may contribute to this service as a "qualified non-physician provider".
- With the exception of direct supervision, pharmacist must meet "incident-to" requirements described in CMS Benefit Policy Manual: Chapter 15, Section 60.
- Applicable to beneficiaries with two or more chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline are eligible for CCM services.
- Requires collaboration with the patient on creating and maintaining a comprehensive care plan.
- Practitioners who furnish a CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code may also bill HCPCS code G0506.
- Patient consent must be obtained at least annually.
- The billing practitioner cannot report both complex and regular (non-complex) CCM for a given patient for a given calendar month. In other words, a given patient receives either complex or non-complex CCM during a given service period, not both.

Code	Description of Service	Estimated Reimbursement
99490 (regular or non-complex)	At least 20 minutes of clinical staff time	$42.17
99487 (complex)	60 minutes of clinical staff time with moderate or high complexity medical decision making	$92.98
99489 (complex)	Each additional 30 minutes of clinical staff time	$46.49
G0506	Add-on code that can be reported once per CCM billing practitioner, in conjunction with CCM initiation	$63.43

Resource: www.cms.gov/apps/physician-fee-schedule
Resource: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
Resource: https://www.acponline.org/system/files/documents/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf

Transitional Care Management

- Pharmacists ***cannot*** bill, but may contribute to this service as a "qualified non-physician provider".
- Claims must be submitted under a Medicare recognized provider, so pharmacist must collaborate with a licensed Medicare provider.
- Requires communication (electronic, telephonic, etc) with patient and/or caregiver within 2 business days of discharge.
- Pharmacists can provide non-face-to-face care coordination components of these visits.
- Pharmacists can be involved in the face-to-face visit and assist provider in medical decision-making services (e.g. med rec).
- With the exception of direct supervision, pharmacist must meet "incident-to" requirements described in CMS Benefit Policy Manual: Chapter 15, Section 60.
- The billing provider cannot report and bill some other codes (i.e. CCM, MTM, home health, etc.) during the time period covered by the TCM services codes.

Code	Description of Service	Estimated Reimbursement
99495	Medical decision making of at least **moderate** complexity during the service period. Face-to-face visit within **14** calendar days of discharge	$166.50
99496	Medical decision making of at least **high** complexity during the service period. Face-to-face visit within **7** calendar days of discharge	$234.97

Resource: https://www.aafp.org/dam/AAFP/documents/practice_management/payment/tcm-faq.pdf
Resource: www.cms.gov/apps/physician-fee-schedule

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