Pharmacist Billing/Coding for Patient Care Clinical Services Quick Reference

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Purpose

This document aims to summarize billing and coding for commonly provided pharmacist patient care services in facility and non-facility clinics. Non-facility (physician based) clinics are physician-owned outpatient practices or hospital-affiliated practices that are considered a separate entity from the hospital by use of a different tax identification number than the hospital. All services must be furnished in accordance with applicable state law. For most current reimbursement rates and/or for reimbursement at your locality, please refer to the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule Search: https://www.cms.gov/medicare/physician-fee-schedule/search

The Medicare Learning Network (MLN) is a useful resource https://www.cms.gov/training-education/medicare-learning-network/resources-training.

ASHP has also created a valuable certificate on this subject ASHP Certificate: Billing and Reimbursement for Patient Care Clinical Services: https://elearning.ashp.org/products/11020/billing-and-reimbursement-for-patient-care-clinical-services-certificate. Refer to the resources section for additional information.

Ambulatory Care Practitioners

"Incident to" Facility Fee Billing

- Facility fee billing is the hospital's technical charge for services provided in an outpatient department of a hospital.
- Pharmacists are not Medicare-eligible providers and generally submit bills under an eligible supervising provider. The criteria for billing a service "incident-to" differ between a physician-based clinic and a hospital-based clinic.
- More detailed information regarding facility fee billing can be found here: Facility Fee Billing FAQ (Oct 2024) (ashp.org)

Code	Description of Service	Estimated Reimbursement*
G0463	Hospital Outpatient Clinic Visit for Assessment & Management of a Patient	$128.87

*As of 2025 CMS Hospital Outpatient Prospective Payment System

The facility fee payment rates are determined annually and can be found online at: https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates

"Incident to" Billing of Evaluation and Management (E/M) CPT/HCPC Codes for Non-Facility

- Medicare eligible providers may bill for pharmacist provided patient care services using "incident to" allowed CPT or HCPC codes. Under Medicare, pharmacists are considered clinical or auxiliary personnel for "incident to" billing purposes.

- Direct payment to pharmacists for patients with Medicaid or private payers may be available based on state rules or payer contracts. When Medicaid or a private payer does not document a specific process to bill for pharmacist patient care services, billing defaults to Medicare regulations.

- Pharmacists remain limited in their ability to receive direct payment for E/M services above the 99211 level unless allowed in their individual states. However, pharmacists able to bill higher level established patient codes should choose the appropriate level for billing their service.

- More detailed information regarding pharmacist billing for using E/M Codes and "incident to" rules for non-facility (physician-based) clinics can be found here: Incident-To Billing FAQ (Oct 2024) (ashp.org)

References:

1. American Medical Association. *2023 CPT® Evaluation and Management (E/M) Descriptors and Guidelines*. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf. Accessed May 28, 2025.
2. Centers for Medicare & Medicaid Services. *Evaluation and Management Services Guide*. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf. Accessed May 28, 2025.

Level of Service: E/M Overview

For CPT 99211, the American Medical Association (AMA) document provides the following guidance:

- It should be used for face-to-face services performed by clinical staff.
- The concept of medical decision making does not apply.
- Its use is for a minimal problem that may not require the presence of the physician or other qualified healthcare provider (QHP).

For other established patient codes (99212-99215), review AMA guidance document as referenced below:

Level	Med Decision Making	Time*	Estimated Reimbursement**	
			Non-Facility	Facility
99211 (Level 1) Minimal	None	<10 minutes	$22.64	$8.41
99212 (Level 2) Problem Focused	Straightforward	10-19 minutes	$54.99	$33.96
99213 (Level 3) Expanded Problem Focused	Low Complexity	20-29 minutes	$88.95	$63.72
99214 (Level 4) Detailed	Moderate Complexity	30-39 minutes	$125.18	$93.80
99215 (Level 5) Comprehensive	High Complexity	40-54 minutes	$175.64	$138.77

*As of 1/1/2021, indicates total time spent on patient's care on date of service, including both face-to-face and non-face-to-face time

**As of 2025 CMS Physician Fee Schedule

E/M= evaluation and management; CC = chief complaint; HPI = history of present illness;
ROS = review of systems; PFSH = past medical, family or social history

References:

3. American Medical Association. *2023 CPT® Evaluation and Management (E/M) Descriptors and Guidelines*. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf. Accessed May 28, 2025.

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

References:

4. Centers for Medicare & Medicaid Services. *Evaluation and Management Services Guide*. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf. Accessed May 28, 2025.

Medication Therapy Management (MTM) CPT Codes

- Must be an interactive, person-to-person, or telehealth (telephone or video) consultation performed by a pharmacist or other qualified provider; and may result in a recommended medication action plan. Must include a review of pertinent patient history, not just drug history, and recommendations to improve medication outcomes and patient compliance.

- Billable through Medicare Prescription Drug (Part D) plan, and some commercial or state Medicaid plans. The physician-based clinic may have specific private payer contracts or state Medicaid opportunities that will allow the utilization of the MTM CPT codes in this setting.

- 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 (list separately and in conjunction with 99605 or 99606)	New and established patient

References:

5. Centers for Medicare & Medicaid Services. *Medicare Prescription Drug Benefit Manual: Medication Therapy Management*. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html. Accessed May 28, 2025.

Education Specific CPT Codes (Education and Training for Self-Management)

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

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

Reference:

6. American Speech-Language-Hearing Association. *Coding and Payment for Case Management*. https://www.asha.org/practice/reimbursement/coding/CaseManagement/. Accessed May 28, 2025.

Billing Considerations for Patients with Diabetes

Diabetes Self-Management Training

- The Centers for Medicare & Medicaid Services uses the term diabetes self-management "training" (DSMT) instead of "education and support" (DSMES) when defining the reimbursable benefit. The term DSMT is used specifically with billing.
- G Codes can be used for DSMT if the program is accredited by the American Diabetes Association (ADA) or the Association of Diabetes Care & Education Specialists (ACDES).
- For DSMT sessions, Medicare covers 10 hours of education in 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, reduced cognition, non-ambulatory, or language barrier.
- All 10 initial hours much be provided within 12 months of the initial date of service or the balance is forfeited.
- 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).

Insulin Pumps

- There are no specific CPT codes for insulin pump training; however, DSMT and MNT (Medical Nutrition Therapy) codes can be used. To bill for this training, the facility must have an ADA or ACDES recognized or accredited DSMT/ES program.

- Pharmacists can also receive reimbursement by becoming certified through the pump company's specific provider training program.

Continuous Glucose Monitor (CGM) Placement and Interpretation

- CPT codes 95249 and 95250 do not have any physician work RVUs (Relative Value Units). These services can be performed by a trained RN, pharmacist, RD, CDE, or MA (within their scope) and billed by the supervising physician advanced practitioner.

- Only a physician or other qualified health care provider (NP, PA, or clinical nurse specialist) can perform and bill for services related to CPT code 95251.

- More detailed information regarding pharmacist billing for patients with diabetes can be found here: Billing Considerations for Patients with Diabetes FAQ (https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/ambulatory-care/Billing-Considerations-for-Patient-with-Diabetes-FAQ-new)

Code	Description of Service	Estimated Reimbursement*
G0108	Used for each 30 min of an individual DSMT/E session	$53.05
G0109	Used for each 30 min of a group (2 to 20 persons)	$15.20/patient
95249	Personal CGM startup/training	$64.05
95250	Professional CGM placement	$139.41

*As of 2025 CMS Physician Fee Schedule

References:

7. Centers for Medicare & Medicaid Services. *CMS Benefit Policy Manual, Chapter 15, Section 300*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-Ioms-Items/Cms012673.html. Accessed May 28, 2025.
8. Association of Diabetes Care & Education Specialists. *Diabetes Coding Table*. https://www.diabeteseducator.org/docs/default-source/practice/Reimbursement-Expert/diabetes-coding-table.pdf?sfvrsn=2. Accessed May 28, 2025.
9. Centers for Disease Control and Prevention. *Medicare Reimbursement Guidelines for DSMES*. https://www.cdc.gov/diabetes-toolkit/php/reimbursement/medicare-reimbursement-guidelines.html. Accessed May 28, 2025.

Medicare Annual Wellness Visits (AWV)

- It is 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. (A pharmacist could assist with these in a co-visit model with a qualified healthcare provider (QHP), however.)

- Initial and Subsequent Medicare Visits can be completed by a medical professional (i.e. pharmacist) under the direct supervision of a physician using "incident to" billing rules. While pharmacists are eligible service providers for AWVs, pharmacists do not serve as the billing provider for these encounters.

- More detailed information regarding pharmacist billing of Medicare Annual Wellness Visits can be found here: Medicare Annual Wellness Visits FAQ (Oct 2024) (ashp.org)

Code	Description of Service	Estimated Reimbursement*
G0438	First Annual Wellness Visit	$160.44
G0439	Subsequent Annual Wellness Visits	$126.47

*As of 2025 CMS Physician Fee Schedule

Reference:

10. Centers for Medicare & Medicaid Services. *Medicare Wellness Visits*. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html. Accessed May 28, 2025.

Chronic Care Management (CCM) and Principal Care Management (PCM) Services

- While pharmacists are eligible service providers for CCM and PCM, pharmacists do not serve as the billing provider for these encounters. Pharmacists can provide the service under the general supervision of the billing practitioner as an "incident to".

- General supervision means overall direction and control, but the physical presence of the billing practitioner is not required.

- 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.

- More detailed information regarding pharmacist billing CCM and PCM Services can be found here: Chronic Care Management FAQ (Oct 2024)Chronic Care Management and Principal Care Management FAQ (Oct 2024)

Code	Description of Service	Estimated Reimbursement*	
		Non-Facility	Facility
99426 (PCM)	At least 30 minutes of clinical staff time	$61.78	$47.55
99427 (PCM)	Each additional 20 minutes of clinical staff time	$50.46	$34.29
99490 (non-complex CCM)	At least 20 minutes of clinical staff time	$60.49	$47.87
99439 (non-complex CCM)	Each additional 20 minutes of clinical staff time	$45.93	$32.99
99487 (complex CCM)	60 minutes of clinical staff time with moderate or high complexity medical decision making	$131.65	$87.01
99489 (complex CCM)	Each additional 30 minutes of clinical staff time	$70.52	$47.23

*As of 2025 CMS Physician Fee Schedule

Reference:

11. Centers for Medicare & Medicaid Services. *Chronic Care Management Services*. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf. Accessed May 28, 2025.

Transitional Care Management (TCM) Codes

- While pharmacists can furnish non-face-to-face services or portions of the face-to-face services as auxiliary personnel, pharmacists cannot serve as the billing provider on the TCM claim. The billing provider must be a physician or a qualified non-physician practitioner.
- 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 providers in medical decision-making services (e.g. med rec).
- More detailed information regarding pharmacist billing for Transitional Care Management Services can be found here: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/ambulatory-care/transitional-care-management-codes

Code	Description of Service	Estimated Reimbursement*	
		Non-Facility	Facility
99495	Medical decision making of at least **moderate** complexity during the service period. Face-to-face visit within **14** calendar days of discharge	$201.2	$134.24
99496	Medical decision making of at least **high** complexity during the service period. Face-to-face visit within **7** calendar days of discharge	$272.68	$182.43

*As of 2025 Physician Fee Schedule

Reference:

12. American Academy of Family Physicians. *Transitional Care Management (TCM) FAQ*. https://www.aafp.org/dam/AAFP/documents/practice_management/payment/tcm-faq.pdf. Accessed May 28, 2025.

Other Billing Codes

There are several other billing codes that have been used successfully by pharmacists and in collaboration with other healthcare providers.

Immunizations

- The vaccines that may be provided by a pharmacist, and the ages for which you are allowed to vaccinate, vary by state law.
- Billing of Immunization involves two separate items that may be reimbursable.
    - The Vaccine
    - Service of Administration of Vaccine (note not all payors will reimburse for vaccines and administration)
- Note that Medicare will not pay for a vaccine administration when billed with a 99211 on the same date of service.

State-Specific Billing

- Medicare Part B and D cover different vaccines and there are state specific laws and regulations that describe reimbursement of pharmacist clinical services.
- Please refer to your state's reimbursement rules or to compare different state's approach to pharmacist reimbursement Advancing Pharmacist Payment Parity Workgroup.

Reference:

13. State of the union: A review of state-based laws and regulations supporting pharmacist payment for clinical services. *J Am Coll Clin Pharm*. 2024;7(9):908-925. doi:10.1002/jac5.2008 https://accpjournals.onlinelibrary.wiley.com/doi/abs/10.1002/jac5.2008

Telehealth

- Telehealth encompasses three distinct terms of telemedicine, telepharmacy, and telecare.
- Types of telehealth delivery include live video, store and forward, remote patient monitoring, and mHealth with mobile technology.
- Some states have passed laws ensuring that insurance reimbursements for telehealth are the same as for non-telehealth services but application of these laws to pharmacy are less clear.
- One common code for reimbursement is Telehealth Originating Site Facility Fee, Q3014 .

References:

14. Centers for Medicare & Medicaid Services. *List of Telehealth Services*. https://www.cms.gov/medicare/coverage/telehealth/list-services. Accessed May 28, 2025.
15. American Society of Health-System Pharmacists. *Telehealth Resource Center*. https://www.ashp.org/pharmacy-practice/resource-centers/telehealth. Accessed May 28, 2025.
16. DeRemer CE. *Telehealth: Strategies for Establishing Pharmacy Practice Models in Ambulatory Care Settings*. 1st ed. American Society of Health-System Pharmacists; 2022.

Telehealth - Remote Physiologic Monitoring (RPM) / Remote Therapeutic Monitoring (RTM) Codes

- Remote physiologic monitoring, also referred to as remote patient monitoring, is a Medicare Part B benefit under the Physician Fees Schedule (PFS)
- A telehealth service option that encompasses the collection, monitoring, and analysis of physiological metrics of a patient's health and related conditions
- Examples include blood pressure monitors, blood glucose meters, weight scales, heart monitors, pulse oximeters, apnea monitors
- CPT Codes include 99091, 99453-99458

Additional Resources:

ASHP Certificate: Billing and Reimbursement for Patient Care Clinical Services

American Society of Health-System Pharmacists. *Billing and Reimbursement for Patient Care Clinical Services [Certificate Program]*. https://www.ashp.org/Professional-Development/Certificate-Programs/Billing-and-Reimbursement. Accessed May 28, 2025.

The Billing and Reimbursement for Patient Care Clinical Services Certificate is intended for pharmacists who are engaged in providing clinical services in a variety of practice settings, and others who are involved in billing for these services. Mary Ann Kliethermes, BS Pharm, PharmD, FAPhA, FCIOM; a recognized leader in reimbursement for pharmacist care services; serves as the editor for this one-of-a-kind, comprehensive resource. Through recorded presentations and readings, this Certificate's curriculum includes, but is not limited to, the following topics:

- Language of healthcare billing
- Reimbursement models including fee-for-service and value-based care models
- Medicare, Medicaid, and commercial insurance payers
- Rules related to eligibility of healthcare professionals to bill for services
- Collaborative practice agreements

- Medical vs. prescription benefits
- Payer mix
- “Incident to” as a billing mechanism
- Facility fee billing
- Care management services – chronic care, principal care, and transitional care
- Medicare Annual Wellness Visits
- Medicare Diabetes Prevention Program and Diabetes Self-Management Training
- Medication Therapy Management
- Continuous glucose monitoring and home INR monitoring
- Telehealth
- Reimbursement in federally qualified health centers (FQHCs) and rural health clinics (RHCs)
- Pharmacist prescribing and reimbursement opportunities at the state level
- Building the business case for pharmacist patient care clinical services
- Outside opportunities to fund patient care clinical services
- Preparing for successful implementation and growth of services
- Engaging with commercial insurance payers to be reimbursed for patient care clinical services
- Healthcare billing cycle
- Electronic billing
- Managing claims before and after adjudication
- Staying current with billing and reimbursement rules and opportunities

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