Internal Medicine Coding Alert

Reader Question: Prescriptions Are Included in E/M Service

Question: My physician heard that there's a code we can report and be paid for just when he writes a prescription. Is this true? If there is such a code, can we report it in addition to an E/M service or when a patient calls in and the physician simply writes a prescription out?

New Jersey Subscriber

Answer: Your physician heard some incorrect information. There is no CPT® code that you should report when your physician simply writes a prescription for a patient. As a matter of fact, CPT® specifically includes writing prescriptions as part of an E/M service. Your office should consider prescription writing as part of the work of other services provided to patients.

Coding solution: If the physician or a nurse in your office sees the patient, you should report the appropriate E/M code -- for example, an established patient code (99211-99215, Office or other outpatient visit for the evaluation and management of an established patient ...).

However, remember that to report 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician) means there must be some sort of evaluation and management of the patient. There must also be documentation to support the visit. Simply taking a patient's vitals, documenting them, and giving the patient medications or a prescription does not support billing of a 99211 office visit unless it is part of a previously established plan of care.

Diagnosis option: There is a diagnosis code, V68.1 (Issue of repeat prescriptions), which might be appropriate for you to report for encounters where that is the primary purpose of the visit. Where provision of the prescription is an incidental part or consequence of the visit, then you should use a diagnosis code that reflects the chief complaint(s) or the diagnosis determined during the encounter.