Outpatient Facility Coding Alert

Reader Question: Writing Prescriptions Are a Part of an E/M Service

Question: A patient with chronic diabetes was seen for prescription refills. The physician checked the status of his diabetes before refilling the medications. What will be the best way to code this visit? Can we use the chronic disease code as the primary diagnosis and the refill code V68.1 as secondary? Or should we use we use the history code of the diabetes as a primary diagnosis code before the refill code?

Virginia Subscriber

Answer: CPT® includes writing prescriptions as part of an E/M service, and the service is essentially just part of the cost of seeing patients, much like office supplies. There is no specific code that payers will reimburse for writing a prescription. Best practice is for the provider to include documentation that shows actual management of the prescription. For example, the plan of care may state that the patient has been tolerating the current medication dosage well, so the physician is renewing the prescription. Or the physician may state that she's choosing a specific drug because it is safer in combination with the patient's diabetes medication.

Caveat: ICD-9-CM includes V68.1 (Issue of repeat prescriptions). But you should not report V68.1 (Z76.0 under ICD-10) with an E/M code if the only reason the patient comes in is to pick up a prescription. In other words, without an actual evaluation and management service, you should not bill an E/M code.