# Eli's Rehab Report

## You Be the Coder: Prescription Writing

**Question:** I heard that there's a code we can bill (and be paid for) to indicate when our physician writes a prescription. What is it, and can we report it in addition to an E/M service? How about when a patient simply calls and the physician writes the prescription?

Florida Subscriber

**Answer:** You may be referring to the ICD-9 code **V68.1** (Issue of repeat prescriptions). If the only reason the patient comes in, however, is to pick up a prescription from the front office and the PM&R provider does not see her for a medically necessary documented E/M service, then you should not bill an E/M code.

Writing prescriptions is included in the table-of-risk part of the medical decision-making key component of an E/M service. There is no separate CPT code for the specific task of writing a prescription.

E/M services require a face-to-face service, so the patient calling for the script and the physician writing or staff faxing a refill to the pharmacy is not separately reportable. On the other hand, if you review the clinical examples for 99211 in the CPT manual's Appendix C, a couple are specifically for an office visit for an established patient who has either lost the prescription or run out of medications, and the provider and/or his staff sees the patient.