



# Master the Distinction Between Level 3 and Level 4 Visits with These Best Practices

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A recurring issue for healthcare practitioners is the frequency with which they find themselves contemplating whether a patient encounter should be classified as a level 3 or level 4 office visit. With a staggering number of ambulatory patient visits falling within these categories, this query has become exceedingly common among providers. Complicating matters further, the coding guidelines from the American Medical Association (AMA) contain gray areas that can contribute to additional confusion.

This article aims to shed light on four key components that will empower all providers to navigate these intricacies with greater confidence when determining the appropriate level of service. Ensuring accurate coding of level 3 and level 4 patient encounters with the appropriate documentation to support it offers practical benefits including optimal reimbursement that recognizes the comprehensive scope of provider efforts, better communication with coders, improved quality of patient records, and better patient care.

#### 4 Key Components

##### 1. Comorbid Conditions

The influence of comorbid conditions on a patient's overall risk cannot be underestimated. It is important to distinguish between healthy, young patients and those whose age and/or co-morbidities increase the probability of complications, even in the setting of an otherwise seemingly simple presentation. Consider, for instance, a 22-year-old individual with a leg wound and no comorbid-

ities, whose risk management would be much lower compared to a 78-year-old patient with the same leg wound, alongside a medical history encompassing diabetes, morbid obesity, and congestive heart failure. Clearly, the latter patient would face a higher risk of complications.

While selecting a level of service, comorbid conditions typically do not factor in—unless they contribute to increased complexity in data review/analysis or pose a greater need for patient management. Thorough documentation of comorbid conditions plays a pivotal role in this process. Each comorbid condition should be meticulously documented in the treatment plan, encompassing all medications and other forms of therapy employed. Additionally, any modifications to the management plan should be duly recorded to ensure comprehensive and accurate documentation.

##### 2. Acute, Uncomplicated Illness vs Acute Illness with Systemic Symptoms

Confusion lies in distinguishing between two categories: “acute, uncomplicated illness/injury,” and “acute illness with systemic symptoms.” To gain clarity, let's explore the definitions outlined in the AMA guidelines.

- *Acute, Uncomplicated Illness/Injury*: This refers to a recent or new short-term problem with a low risk of morbidity, where treatment is deemed necessary. There is minimal to no risk of mortality with treatment, and the expectation is a complete recovery without any functional impairment. An acute, uncomplicated illness is typically self-limited or minor in nature. Even when its resolution does not follow a definite and prescribed course, the illness or injury falls into this category. Examples include cystitis, allergic rhinitis, or a simple sprain.<sup>1</sup>
- *Acute Illness with Systemic Symptoms*: This term applies to an illness that manifests systemic symp-



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toms and carries a high risk of morbidity if left untreated. In cases involving general systemic symptoms, such as fever, body aches, or fatigue, where treatment is aimed at alleviating symptoms, shortening the duration of the illness, or preventing complications, clinicians should refer to acute, uncomplicated illness/injury definitions to make a determination. Systemic symptoms may not be general but rather specific to a single system. Examples include pyelonephritis, pneumonitis, or colitis.

When it comes to classifying most uncomplicated cases of otitis media, otitis externa, sinusitis, conjunctivitis, and similar illnesses with normal vital signs, as other examples, there is generally a consensus that they fall under the acute, uncomplicated illness category. However, what about patients who present with additional factors that have relevance?

Consider, for instance, a patient with left otitis media exhibiting a temperature of 101.6°F and a heart rate of 106 beats/minute, or a patient who has tested positive for influenza, with a temperature of 102.1°F and a heart rate of 118 beats/minute. These cases pose a challenge as they deviate from the usual straightforward classification.

To address such complex scenarios, it becomes crucial to shift the clinical focus toward Systemic Inflammatory Response Syndrome (SIRS). By considering the parameters outlined within the SIRS criteria, which include indicators, such as heart rate, temperature, respiratory rate, and white blood cell count, providers can gain a better understanding of the patient's systemic response and evaluate the potential severity of the condition.

Delving deeper into the details of these challenging cases and leveraging the framework provided by SIRS criteria allows healthcare providers to make informed decisions regarding appropriate categorization and treatment pathways for patients presenting with acute, uncomplicated illnesses that exhibit additional clinical complexities.

SIRS is defined by the National Institutes of Health as, “an exaggerated defense response of the body to a noxious stressor (infection, trauma, surgery, acute inflammation, ischemia or reperfusion, or malignancy, to name a few) to localize and then eliminate the endogenous or exogenous source of the insult. It involves the release of acute-phase reactants, which are direct mediators of widespread autonomic, endocrine, hematological, and immunological alteration in the subject. Even though the purpose is defensive, the dysregulated cytokine storm can cause a massive inflammatory cascade leading to reversible or irreversible end-organ dysfunction and even death.”<sup>2</sup>

Objectively, SIRS is defined by the satisfaction of any two of the criteria below:

- Body temperature over 100.4°F or under 96.8°F.
- Heart rate greater than 90 beats/minute
- Respiratory rate greater than 20 breaths/minute or partial pressure of CO<sub>2</sub> less than 32 mmHg
- Leukocyte count greater than 12,000 or less than 4,000 or over 10% immature forms or bands.<sup>2</sup>

Many adult patients with acute febrile illnesses will meet these fairly liberal and non-specific SIRS criteria and consequently will also meet systemic symptoms criteria, for coding purposes, as an “acute illness with systemic symptoms.” Other common systemic symptoms worth being familiar with and documenting include (but are not limited to):

- Nausea, diarrhea, or vomiting
- Loss of appetite
- Malaise or fatigue
- Confusion or dizziness that is not primarily neurological
- Rash in a condition that is not primarily dermatological
- Joint or muscle pain in a condition that is not primarily orthopedic

By understanding these distinctions, healthcare professionals can navigate the complexity of differentiating between acute, uncomplicated illness/injury and acute illness with systemic symptoms, thereby ensuring accurate categorization and appropriate treatment decisions.

### 3. Pediatric Patients

Pediatric patients may require a higher level of service that should be reflected in the documentation. It is important not to hastily assign a level 3 visit to a pediatric patient who has tested positive for strep, for example. In many cases, these encounters should be categorized as level 4 visits when appropriate documentation is provided.

Consider an illustrative example: A 4-year-old child arrives at the clinic accompanied by the father who reports the child has been experiencing a fever, loss of appetite, and a sore throat for the past 2 days. Point-of-care (POC) tests for strep throat and COVID-19 are conducted. The strep test yields a positive result, and you prescribe amoxicillin as treatment.

In this scenario, due to the ordering of 2 POC tests (strep and COVID-19), the documentation of an independent historian who provides the history of the present illness (in this case, the father), as well as the prescription of amoxicillin, the visit qualifies as a level 4 office visit. These factors contribute to the complexity and documentation requirements necessary to justify the higher level of service.

By recognizing the significance of these elements and

appropriately documenting the details of the encounter, healthcare providers can accurately assign the appropriate level of service for pediatric patients, ensuring proper reimbursement and reflecting the level of care provided.

#### 4. Documentation

Undoubtedly, documentation stands as the cornerstone when it comes to selecting the correct level of service. Neglecting to document crucial elements, such as comorbid conditions, an independent historian, and over-the-counter (OTC) or prescription medications, among others, can inadvertently confine healthcare providers to level 3 categorization. Consequently, this not only deprives them of rightful reimbursement but also hampers the overall revenue generation for the healthcare organization, failing to recognize the comprehensive scope of their efforts. To ensure accurate documentation and optimize reimbursement, consider the following documentation practices:

- **Comorbid Conditions:** Thoroughly document all relevant comorbid conditions, acknowledging their impact on patient management and the associated complexities.
- **Independent Historian:** Whenever an independent historian provides critical information regarding the patient's history, ensure it is duly documented, acknowledging the source and their relationship to the patient.
- **OTC/Prescription Medications:** Record all OTC and prescription medications prescribed or recommended during the encounter, demonstrating the comprehensive nature of the care provided.
- **Differential Diagnosis:** Incorporating a summary of the differential diagnosis in your treatment plan can prove highly beneficial. By doing so, you provide valuable insight to the coder regarding the complexity of the patient's condition, ultimately contributing to a more accurate coding process. Including a differential diagnosis within the treatment plan serves multiple purposes. First, it demonstrates your thoughtful consideration of various potential diagnoses based on the patient's symptoms, history, and examination findings. This showcases the depth of your clinical reasoning and your comprehensive approach to patient care. Secondly, a documented differential diagnosis helps coders to better understand the complexity of the case. It provides them with valuable information, enabling them to assign appropriate codes that accurately reflect the intricacies involved in managing the patient's condition. By adopting this practice, healthcare providers can facilitate effective communication with coders, resulting in improved

coding accuracy and a more thorough understanding of the patient's medical complexity.

#### ■ **Treatment Options or Data Options Considered But Not Performed:**

Even if a patient refuses a recommended course of action, such as declining a prescribed medication like nirmatrelvir/ritonavir (Paxlovid) despite a positive POC COVID-19 test, the refusal still holds significance within the realm of prescription management. When a patient declines a recommended test or treatment, clinicians should document the refusal and the specific details surrounding it. In doing so, providers can demonstrate their comprehensive evaluation and management approach, as well as the time, effort, and consideration given to different treatment options. They also uphold the integrity of their records, ensuring comprehensive documentation that accurately reflects the decision-making process and the patient's role in their own healthcare journey.

By adhering to these documentation guidelines and capturing the essential elements of the patient encounter, healthcare providers can accurately reflect the level of service delivered. This ensures fair reimbursement, optimizes revenue, and acknowledges the extensive effort and expertise invested in patient care.

#### Conclusion

All healthcare providers should possess a comprehensive understanding of medical coding guidelines. This knowledge empowers them to accurately assign appropriate codes for patient encounters, reflecting the complexity and specificity of the services rendered. However, achieving coding success requires thorough documentation. Thorough documentation serves as the linchpin in the coding process. It allows healthcare providers to capture the specific details of the patient encounter, including relevant diagnoses, procedures, treatments, and other pertinent information.

Accurate coding of level 3 and level 4 office visits not only ensures appropriate reimbursement but also facilitates effective communication among healthcare professionals, researchers, and payer entities. It contributes to the reliability and integrity of medical records, allowing for precise analysis, improved decision-making, and enhanced patient care. ■

#### References

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