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COFFEE & CODING

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MDM Level 5: A Quick Refresher on a Complex Subject

We continue to see that, across all medical specialties, physicians are still nervous about billing for Level 5 office visits. I consistently find that many (if not most) providers code for Level 4 even when the patient encounter meets all the criteria for Level 5 and adequate documentation is included.

Why? When I ask this question, the answer I most often receive is that physicians fear being audited and fined for failing to meet Level 5 requirements. When I audit encounters involving these physicians, I frequently find that they not only have done the work to qualify for Level 5 but have exceeded these requirements; they could have billed for Level 6 if such a level existed.

Coding at a level below what is appropriate creates two problems for provider groups. First, they needlessly leave billable revenues that they have legitimately earned on the table. Not many groups can afford to do that in an environment where costs are rising and reimbursements are shrinking. Second, though it may seem counterintuitive, providers who bill at a level below what the evidence supports risk being audited, too; it happens to those being underpaid by insurers as well as those who are found to "over-code."

So, this is an appropriate time for a quick refresher on Level 5. Let's start with something basic that is nevertheless often forgotten: To meet the criteria for Level 5, there must be a high level of risk. Level 5 is mainly for patients who require complex treatment or who have severe illnesses or critical care diagnoses; it is also used for billing by time when coordinating care and the time involved reaches the threshold of 40 minutes for 99215 and 60 minutes for 99205.

Now let's look at some examples of applying medical decision-making (MDM) guidelines for Level 5 (please bear in mind this is not an all-inclusive list).[1] All of these examples involve risk—the third category in Level 5 MDM, after (1) the number and complexity of problems addressed and (2) the amount and/or complexity of data. Risk is the category where we tend to see the most problems (in no small part because the wording in the AMA's E/M coding graphic is rather vague).

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[1] PCC_2024_E_M_Coding_Tool.pdf

Example 1. Drug therapy requires intensive monitoring for toxicity or involves a decision about parental-controlled substances. What types of drugs are we talking about here? Some examples would be drugs used in chemotherapy, anticoagulants, immunosuppressive drugs, and some mental health drugs (such as Chlorpromazine, Fluphenazine, Haloperidol, Loxapine, Perphenazine, Thiothixene, and Thioridazine).[2]

Example 2. Decision regarding elective major surgery with identified patient or procedure risk factors. This one is self-explanatory, depending on the comorbidity involved (e.g., heart issue or cancer).

Example 3. Decisions about emergency major surgery. Apply Level 5 if the patient needs immediate major surgery due to a life-threatening condition (e.g., acute appendicitis or a ruptured aneurysm).

Example 4. Decision regarding hospitalization or escalation of hospital-level care. When clinicians make critical decisions for admission into the hospital, call ahead to the Emergency Department with a "warm handoff" stating the location and person/title in the ED called with the assumption of admission.

Example 5. Decision not to resuscitate or to de-escalate care due to poor prognosis. Apply Level 5 if the prognosis is poor and the clinician makes the decision against aggressive resuscitation efforts or opts for palliative care. Level 5 is also appropriate if the patient chooses DNR/DNI.

Don't miss our "Ask the Experts" Q&A webinar on March 27!

Click here to register: https://zoom.us/webinar/register/WN_DR96lTB4QVWgI5b2wxmKuw

If you have an E/M coding question you'd like our experts to address during the webinar, please submit it here: https://survey.hsforms.com/1AI9VoMe-SK6MSUuAypFnmgnig0s

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2 https://psychcentral.com/pro/laboratory-monitoring-when-prescribing-psychotropics

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