



Evaluation and management – understanding the 2024 office visit and nursing facility changes

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Source: AMA CPT® Book 2024

Effective January 1, 2024, office or other outpatient visit CPT® codes 99202-99215 and nursing facility codes 99306 and 99308 include revised code descriptions. Over the past few years, the AMA has worked to revise evaluation and management (E/M) guidelines to reduce the burden on providers and coders. Gone are the days of counting “bullets” for history and examination. E/M codes now require a medically appropriate history and/or examination. Code selection is based on medical decision making (MDM) or time.

To better align with past changes, codes 99202-99215 have been revised to remove the time ranges (for example, 15 to 29 minutes of total time). Instead, these codes include the number of minutes that must be met or exceeded. The descriptions also indicate that this includes the total time on the date of the encounter. This change was necessary to create consistency across the E/M codes in the CPT book.

In addition to the changes for office or other outpatient visits, 2 nursing facility codes include revisions. For initial nursing facility care code 99306, the total time that must be met or exceeded has been changed from 45 to 50 minutes. For subsequent nursing facility care code 99308, the time has been changed from 15 to 20 minutes.

See below for the new code descriptions:

99202: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99204: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

99212: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99214: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99215: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

99306: Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.

99308: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

Coding scenario:

HPI: 52-year-old female new patient presents today for frequent and painful urination. This started 3 days ago and has progressively gotten worse. The patient describes the pain as burning. She states that she has been getting up 3 times every night to urinate. She had a fever with a temperature of 99.8 yesterday afternoon. She has not tried any over-the-counter medications.

Past medical history: No prior urinary issues.

Family/social history: No family urologic history. The patient drinks alcohol occasionally when she is out with friends. Nonsmoker.

Review of symptoms: All other review of systems are negative.

Physical exam: BP 129/75, Pulse 68, Temp 99.4. No acute distress. Mood and affect are appropriate. Skin is normal to inspection. Neck shows no thyromegaly. Regular rate and rhythm peripherally. Neck and groin show no adenopathy. Abdomen soft and nontender.

Urinalysis is consistent with UTI with 71 WBC, 37 RBC, 2+ leukocyte esterase, negative nitrites. This was sent for culture.

Impression: Urinary tract infection

Plan: Prescription given for ciprofloxacin 500mg/day for 3 days. Patient instructed to take Tylenol PRN for fever. Follow up if symptoms do not improve. 18 minutes was spent reviewing lab tests, ordering medications, and performing an examination and evaluation on the patient.

ICD-10-CM diagnosis code

N39.0: Urinary tract infection, site not specified

Rationale:

In the alphabetic index, the main term “Infection, infected, infective (opportunistic)” can be found with the subterm “urinary (tract)” to arrive at ICD-10-CM code N39.0. According to ICD-10-CM guideline I.C.18.b, signs and symptoms that are commonly associated with a disease process should not be reported in addition to the definitive diagnosis. Fever and frequent and painful urination are routinely associated with a urinary tract infection, so ICD-10-CM codes are not selected for these symptoms.

CPT code

99202: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

Rationale:

Number and complexity of problems addressed:

In this scenario, the urinary tract infection is an acute uncomplicated illness, which is classified as “low” in the number and complexity of problems addressed. This is defined in the CPT manual as “a recent or new short-term problem with low risk of morbidity for which treatment is considered.”

It may be tempting to choose an acute illness with systemic symptoms because of the fever. However, the definition for that option indicates the patient would be at high risk for morbidity without treatment. Instructions in the CPT book indicate “for systemic general symptoms such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions of self-limited or minor problem or acute, uncomplicated illness or injury.” The acute, uncomplicated illness is the best option for this documentation.

Amount and/or complexity of data to be reviewed and analyzed:

The provider ordered and reviewed the urinalysis results. According to the American Medical Association CPT Assistant November 2020, page 5, dual credit is not given for ordering and reviewing the same test. The urinalysis counts as one unique test. The provider also ordered a urine culture, which is a second unique test. Two unique tests fall under “limited” in this section.

Risk of complications and/or morbidity or mortality of patient management:

The provider prescribes ciprofloxacin, and prescription drug management is considered a moderate risk of morbidity from additional diagnostic testing or treatment.

Final E/M calculation:

The criteria for 2 out of 3 medical decision making (MDM) elements must be met to choose a level. Documentation supports:

- Number and complexity of problems addressed at the encounter: low
- Amount and/or complexity of data to be reviewed and analyzed: limited
- Risk of Complications and/or morbidity or mortality of patient management: moderate risk

The provider meets the criteria for low medical decision making. Documentation indicates the patient is new, so 99203 is the appropriate E/M code.

Remember, an E/M level can also be selected based on time. The provider documented that they spent 18 minutes of total time on the date of the encounter. Per the updated code description for 2024, this would meet the criteria for a level 2 (99202) new patient E/M service as 15 minutes was met or exceeded. However, the provider should report the code that is most advantageous to them, based on either medical decision making or time. In this scenario, the provider can report a higher level by using the medical decision making criteria rather than time.



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