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OFFICE VISIT DURING TCM PERIOD

Q When a recently hospitalized patient presents for a visit during the transitional care management (TCM) period (seven days or 14 days post-discharge, depending on the level of TCM) but the problems I address during the visit are unrelated to the reason for hospitalization, can we report an office visit separately and then schedule the patient for another visit for TCM purposes?

A CPT is clear that the *first* office visit following hospital discharge is included in the TCM service. Remember that TCM's value (2.78 work RVUs for 99495 and 3.79 work RVUs for 99496) is based on oversight of all the patient's health needs during the TCM period.

There is nothing that limits the TCM visit to only those problems addressed during the patient's hospitalization, so you could use that first visit to address the patient's other problems too. But if the patient's health care needs clinically indicate another visit to further address health problems, that second visit would be separately reported. The Centers for Medicare & Medicaid Services (CMS) says you may separately report "reasonable and necessary E/M services" during the TCM period, and it has a list of other codes clinicians can bill concurrently with TCM.¹

ABOUT THE AUTHOR

Cindy Hughes is an independent consulting editor based in El Dorado, Kan., and a contributing editor to *FPM*. Author disclosure: no relevant financial relationships.

EDITOR'S NOTE

Reviewed by the *FPM* Coding & Documentation Review Panel. Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

SEQUELAE OF PREMATURE BIRTH

Q When caring for children impacted by premature birth (e.g., delayed development for chronological age), is it appropriate to report a diagnosis code for premature birth?

A Yes. First report the code for the condition you're managing (e.g., F88, "Other disorders of psychological development") and then report the appropriate code for premature birth from category P07 ("Disorders of newborn related to short gestation and low birth weight, not elsewhere classified").

Though the ICD-10 guidelines clearly state that clinicians may report category P07 codes when prematurity and low birth weight affect the current health status of a child or adult, there is often confusion about using these codes outside the neonatal period (day of birth through 28th day of life). If you receive a denial due to claims edits that limit category P07 to services provided during the neonatal period, you should appeal it based on HIPAA's requirement that payers follow the ICD-10-CM guidelines.

MEDICARE COVERAGE FOR BLOOD-BASED COLORECTAL CANCER SCREENING

Q Does Medicare cover screenings for colorectal cancer for all beneficiaries when we use a blood-based biomarker test (G0327)? If so, how often is the service covered?

A Colorectal cancer screening by blood-based biomarker test (G0327) is a covered preventive benefit once every three years only for Medicare beneficiaries who are



50-85 years old, do not have symptoms of colorectal cancer, and do not meet the criteria for high-risk screening (e.g., personal or close family history of

adenomatous polyp or colorectal cancer). If the patient has had any screening test for colorectal cancer within the past 35 months, Medicare will deny the claim due to frequency limitations. The appropriate diagnosis for the service reported with G0327 is either Z12.11 ("Encounter for screening for malignant neoplasm of colon") or Z12.12 ("Encounter for screening for malignant neoplasm of rectum").

VASCULAR DEMENTIA DIAGNOSIS CODING

Q When my practice reports code F01.50 for vascular dementia, we sometimes receive claim denials with instructions to report an appropriate primary code. What is an appropriate primary code for F01.50?

A To report a diagnosis of vascular dementia with F01.50, you must first document and list the underlying cause, such as cognitive deficits following cerebral infarction (I69.31-). Alternatively, when there is no documentation of an underlying condition, you can report codes in category F03.9- (unspecified dementia) instead of F01.50. **FPM**

1. Transitional care management services. CMS Medicare Learning Network. May 2023. Accessed Aug. 1, 2023. <https://www.cms.gov/files/document/mln908628-transitional-care-management-services.pdf>

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