



June 1, 2011



The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Section 1664 of the National Defense Authorization Act for Fiscal Year 2008 (P.L. 110-181) requires the Secretary of Defense and the Secretary of Veterans Affairs (VA) to jointly submit a report describing the changes undertaken within their Departments to ensure that Service members and Veterans with traumatic brain injury (TBI) receive a medical designation concomitant with their injury. We have submitted three interim reports to document our progress implementing these modifications. This letter transmits our final report in response to this legislation.

Previous coding classifications prevented adequate characterization of the spectrum of TBI injury and its symptomatic manifestations, a problem well known to the medical community at-large. Specifically, Congress asked the Departments of Defense (DoD) and VA to address the coding of certain TBI symptoms as mental disorders. In response, DoD and VA clinical and medical coding communities developed a consolidated, bi-phased proposal of coding revisions, which recommended changes to the current TBI International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding classifications. DoD and VA worked closely with medical societies and the National Center for Health Statistics to develop proposals. In addition, DoD and VA developed and jointly implemented a common case definition for TBI.

The first phase of the proposal introduced new codes for emotional and behavioral symptoms, such as irritability, nervousness, and emotional lability (an overly exaggerated emotional response). Under previous coding rules, these conditions would have been classified as non-psychotic mental disorders. In addition, new codes for personal history of TBI, TBI screening, and several technical changes to ICD-9-CM were approved that will improve the classification of TBI and TBI-related symptoms. These codes were activated on October 1, 2009, and implemented throughout DoD and VA (enclosure).

The second phase proposed new codes for cognitive disorders. These codes capture for the first time a spectrum of cognitive disorders frequently associated with TBI. The new codes were released on October 1, 2010. In addition, these changes to ICD-9-CM will link to ICD-10-CM, the next generation of disease classification codes, due for implementation in the United States by 2013.

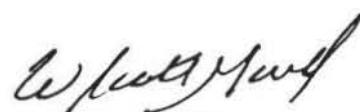
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Thank you for your interest in helping support our Service members and their families.

Sincerely,



Clifford L. Stanley
Under Secretary of Defense
Personnel and Readiness



W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Enclosures:
As stated

cc:
The Honorable Thad Cochran
Vice Chairman



June 1, 2011



The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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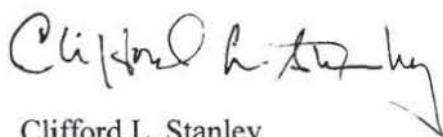
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Under Secretary of Defense
Personnel and Readiness



W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Enclosures:
As stated

cc:
The Honorable John McCain
Ranking Member



June 1, 2011



The Honorable Jim Webb
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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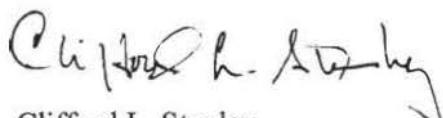
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Clifford L. Stanley
Under Secretary of Defense
Personnel and Readiness



W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Enclosures:
As stated

cc:
Ranking Member



June 1, 2011



The Honorable Howard P. "Buck" McKeon
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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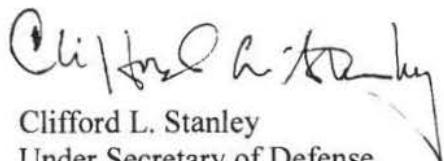
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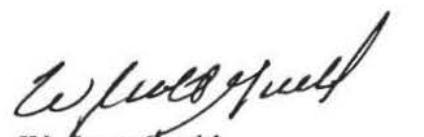
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Clifford L. Stanley
Under Secretary of Defense
Personnel and Readiness



W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Enclosures:
As stated

cc:
The Honorable Adam Smith
Ranking Member



June 1, 2011



The Honorable Joe Wilson
Chairman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Clifford L. Stanley
Under Secretary of Defense
Personnel and Readiness



W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Enclosures:
As stated

cc:
The Honorable Susan A. Davis
Ranking Member



June 1, 2011



The Honorable Harold Rogers
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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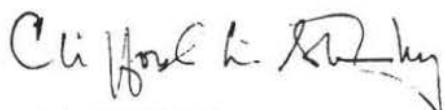
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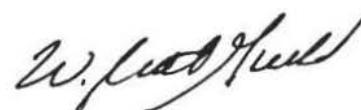
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Clifford L. Stanley
Under Secretary of Defense
Personnel and Readiness



W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Enclosures:
As stated

cc:
The Honorable Norman D. Dicks
Ranking Member



June 1, 2011



The Honorable Patty Murray
Chairman, Committee on Veterans Affairs
United States Senate
Washington, DC 20510

Dear Madam Chairman:

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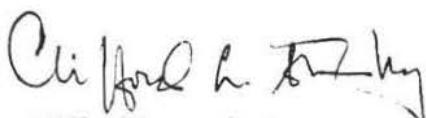
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Clifford L. Stanley
Under Secretary of Defense
Personnel and Readiness



W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Enclosures:
As stated

cc:
The Honorable Richard Burr
Ranking Member



June 1, 2011



The Honorable Jeff Miller
Chairman, Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

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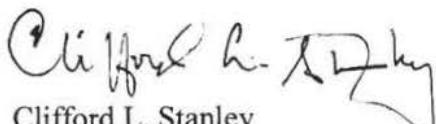
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Under Secretary of Defense
Personnel and Readiness



W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Enclosures:
As stated

cc:
The Honorable Bob Filner
Ranking Member



June 1, 2011



The Honorable Tim Johnson
Chairman, Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
United States Senate
Washington, DC 20510

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Deputy Secretary
Department of Veterans Affairs

Enclosures:
As stated

cc:
The Honorable Mark Kirk
Ranking Member



June 1, 2011



The Honorable John Culberson
Chairman, Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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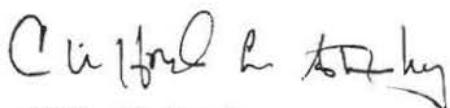
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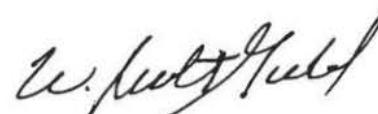
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Thank you for your interest in helping support our Service members and their families.

Sincerely,



Clifford L. Stanley
Under Secretary of Defense
Personnel and Readiness



W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Enclosures:
As stated

cc:
The Honorable Sanford D. Bishop, Jr.
Ranking Member



June 1, 2011



The Honorable Daniel K. Inouye
Chairman, Subcommittee on Defense
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Section 1664 of the National Defense Authorization Act for Fiscal Year 2008 (P.L. 110-181) requires the Secretary of Defense and the Secretary of Veterans Affairs (VA) to jointly submit a report describing the changes undertaken within their Departments to ensure that Service members and Veterans with traumatic brain injury (TBI) receive a medical designation concomitant with their injury. We have submitted three interim reports to document our progress implementing these modifications. This letter transmits our final report in response to this legislation.

Previous coding classifications prevented adequate characterization of the spectrum of TBI injury and its symptomatic manifestations, a problem well known to the medical community at-large. Specifically, Congress asked the Departments of Defense (DoD) and VA to address the coding of certain TBI symptoms as mental disorders. In response, DoD and VA clinical and medical coding communities developed a consolidated, bi-phased proposal of coding revisions, which recommended changes to the current TBI International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding classifications. DoD and VA worked closely with medical societies and the National Center for Health Statistics to develop proposals. In addition, DoD and VA developed and jointly implemented a common case definition for TBI.

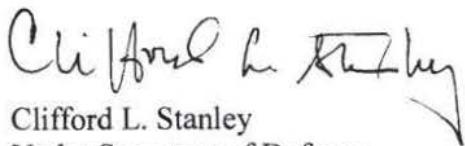
The first phase of the proposal introduced new codes for emotional and behavioral symptoms, such as irritability, nervousness, and emotional lability (an overly exaggerated emotional response). Under previous coding rules, these conditions would have been classified as non-psychotic mental disorders. In addition, new codes for personal history of TBI, TBI screening, and several technical changes to ICD-9-CM were approved that will improve the classification of TBI and TBI-related symptoms. These codes were activated on October 1, 2009, and implemented throughout DoD and VA (enclosure).

The second phase proposed new codes for cognitive disorders. These codes capture for the first time a spectrum of cognitive disorders frequently associated with TBI. The new codes were released on October 1, 2010. In addition, these changes to ICD-9-CM will link to ICD-10-CM, the next generation of disease classification codes, due for implementation in the United States by 2013.

The collaborative efforts of DoD and VA have effected a noteworthy change for TBI coding classification within the medical community at-large. These changes are pivotal to provide Service members with TBI a medical designation concomitant with their injuries rather than a medical designation that assigns a generic classification. Furthermore, these changes will significantly improve the identification, classification, tracking, monitoring, and reporting of TBI-related symptoms among Service members and Veterans. Although we have improved TBI diagnostic designations through our collaborative efforts, we plan to continue working to improve other deficiencies identified in ICD-9-CM, such as inappropriately coding certain intracranial injuries as concussion. Because this code system will be phased out by 2013, we will focus our efforts on ICD-10-CM.

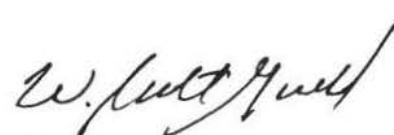
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Clifford L. Stanley

Under Secretary of Defense
Personnel and Readiness



W. Scott Gould

Deputy Secretary
Department of Veterans Affairs

Enclosures:

As stated

cc:

The Honorable Thad Cochran
Vice Chairman



June 1, 2011



The Honorable C. W. Bill Young
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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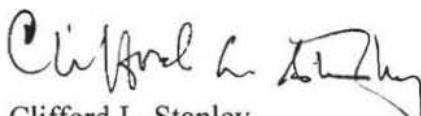
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Clifford L. Stanley
Under Secretary of Defense
Personnel and Readiness



W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Enclosures:
As stated

cc:
The Honorable Norman D. Dicks
Ranking Member



Defining
EXCELLENCE
in the 21st Century

Health Information Management

Fact Sheet
Coding Guidance for Traumatic Brain Injury

Updated October 2010

IMPORTANT NOTE: This updated Fact Sheet reflects use of codes effective 10/1/2010, ALL PREVIOUS VERSIONS OF THIS FACT SHEET ARE RESCINDED.

BACKGROUND: VHA has a need, to the best of its ability, to uniquely identify and report on Traumatic Brain Injury (TBI) and conditions, syndrome, and symptoms associated resulting from such injuries. VHA in conjunction with DoD have championed the development of TBI codes to more accurately capture and reflect TBI and its effects.

CODING THE INITIAL ENCOUNTER: An appropriate injury code from the 8xx series will be coded ONCE, at the time of the **initial** encounter. An initial encounter is defined as the first time the patient is seen for the injury, regardless of when the injury took place. If an injury occurred in the past several months or even years but the patient has never sought treatment for the injury previously, the first time the patient is SEEN for the injury is considered the initial treatment. If a practitioner is seeing a patient for treatment of an injury for the first time, and the treatment for the injury has previously been provided by any other medical professional, it is NOT an initial encounter for that injury. In order to code an initial TBI injury, documentation must clearly state that the encounter being coded is the **INITIAL** or first encounter for treatment of the TBI.

An initial encounter does not refer to the first time the patient is seen by each clinician for that particular TBI. Rather, an initial encounter is defined as the first time the patient is seen by any medical professional for the TBI, regardless of when the injury took place even if it occurred several weeks, months or years prior to the encounter. Clinical documentation must clearly indicate that the encounter coded is the initial encounter for that particular injury. TBI may be associated with skull fracture (800-801 or 803-804) or without skull fracture (850-854). A fourth digit is required that further describes the 8XX series codes. A fifth

digit is required to describe the level of consciousness associated with the TBI. In order to ensure the most accurate and appropriate level of coding, documentation must clearly state if there was a loss of consciousness (LOC) due to the injury and, if so, the duration of LOC. If documentation does not clearly define the duration of LOC, then unspecified state of consciousness must be coded.

EXAMPLE: Veteran is seen for the first time at a VA facility for memory problems. During the history, the practitioner determines on the basis of Veteran's self-report that there was brief loss of consciousness less than 30 minutes due to an improvised explosive device (IED) blast. There is no evidence in the record of skull fracture. The Veteran reports that he has never sought treatment for the condition, which is causing significant problems at work. The practitioner codes mild TBI (850.11) and codes the initial encounter for memory problems (780.93) due to TBI.

In order to ensure the most accurate and appropriate level of coding, documentation must clearly state if there was a loss of consciousness (LOC) due to the injury and the duration of the LOC. If documentation does not clearly define the LOC then unspecified state of consciousness must be coded. When appropriate an E code from the E99x series may be assigned. Please refer to your Health Information Management Coding Department for further guidance on E codes.

CODING FOLLOW UP CARE: For follow up visits for symptoms directly related to a previous TBI, the symptom code(s) that best represents the patient's chief complaint or symptom(s) (e.g., headache, insomnia, vertigo) are coded, followed by the appropriate late effect code (905.0 or 907.0). Late effects include any symptom or sequelae of the injury specified as such, which may occur *at any time after the onset of the injury*.

The pairing of the symptom code and the late effect code is the ONLY WAY that symptoms can be causally and uniquely associated with TBI and is essential to the accurate classification of TBI.

EXCEPTION FOR REHABILITATION: For TBI patients who receive inpatient or outpatient rehabilitation, the first-entered diagnosis is the purpose of the encounter from the V57.x series, followed by the symptom treated, and then the appropriate late effect (905.0 or 907.0). Use additional codes for the specific residuals.

USE of V15.52 CODE: V15.52 Personal history of traumatic brain injury was developed to indicate that previous TBI occurred and may impact current care. The V15.52 code is not used in conjunction with the late effect codes; rather the V code is used when no other code is available to reflect a previous TBI. Normally, the V15.52 code is used to identify a personal history of injury with or

without a confirmed diagnosis. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

TBI SCREENING CODE: Code V80.01 should be used if TBI screening occurs at a visit, whether or not the screening is positive. A TBI diagnosis code should not be entered for a positive screen since a positive TBI screen does not indicate a TBI diagnosis. A TBI diagnosis code can only be entered for the encounter at which the diagnosis is made.

Examples of ICD-9-CM Codes Typically Associated with TBI

Series Code	800-804 & 850-854 Series Codes	
		Description
800		Fractures of vault of skull - require a fourth and fifth digit
801		Fractures of base of skull - require a fourth and fifth digit
802		Fracture of face bones - require a fourth and fifth digit
803		Other and unqualified skull fractures - require a fourth and fifth digit
804		Multiple fractures involving skull or face with other bones - require a fourth and fifth digit
850		Concussion - require a fourth and fifth digit
851		Cerebral laceration and contusion - require a fourth and fifth digit
852		Subarachnoid, subdural, and extradural hemorrhage, following injury - require a fourth and fifth digit
853		Other and unspecified intracranial hemorrhages following injury - require a fourth and fifth digit
854		Intracranial injuries of other and unspecified nature - require a fourth and fifth digit

Late Effect Codes

Late Effect Code (must be used with all follow-up TBI encounters)	
905.0	Late effect of intracranial injury with skull or facial fracture
907.0	Late effect of intracranial injury without skull or facial fracture

799.2x Emotional / Behavioral Symptoms

ICD-9 Code	Symptom
799.21	Nervousness
799.22	Irritability
799.23	Impulsiveness
799.24	Emotional lability
799.25	Demoralization and apathy
799.29	Other signs and symptoms involving emotional state

799.5x Cognitive Symptoms

ICD-9 Code	Symptom
799.51	Attention and concentration deficit
799.52	Cognitive communication deficit
799.53	Visuospatial deficit
799.54	Psychomotor deficit
799.55	Frontal lobe and executive function deficit
799.59	Other signs and symptoms involving cognition

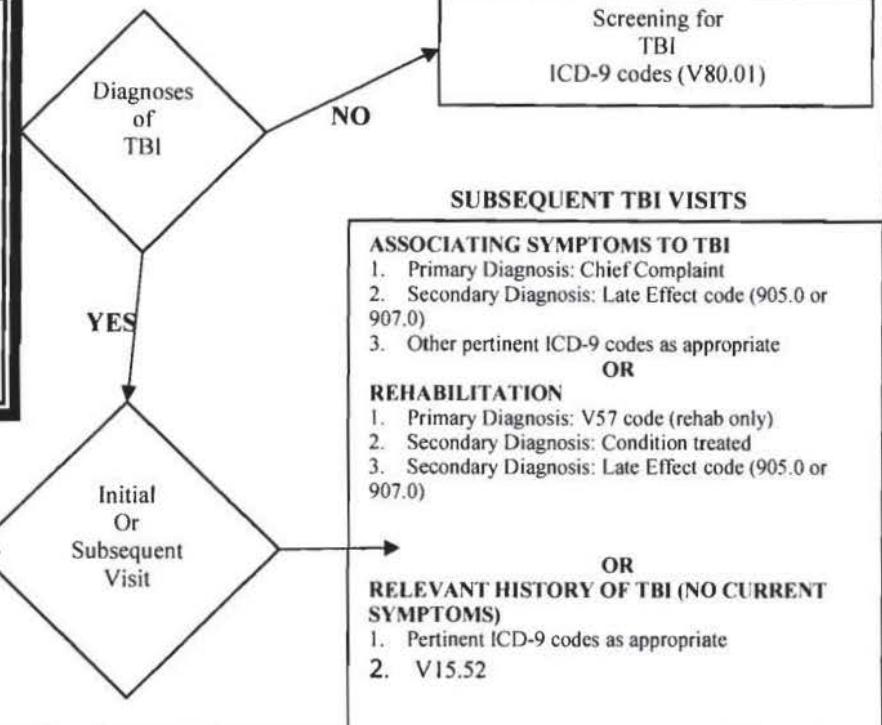
Note: Memory deficits will be coded as 780.93.

**VA
ICD-9 CM
CODING GUIDANCE
For
TRAUMATIC BRAIN
INJURY
(TBI)**

INITIAL TBI DIAGNOSIS

Initial TBI Diagnosis

1. Primary Code: Brain Injury, 800 series
2. Other ICD-9 codes for symptoms (e.g., memory deficit 780.93)



Look Before You Code



Before assigning a primary diagnosis for an initial TBI, please review all existing documentation, including that from outside sources, to ensure that a previous TBI code has not been assigned.

Late Effect Code

All follow-up treatment for TBI **symptoms** must include the code for the signs or symptoms associated with the previous TBI **IN ADDITION TO** one of two codes to reflect the current symptoms are due to a late effect of a previous injury 905.0 (late effect of intracranial injury with skull or facial fracture) or 907.0 (late effect of intracranial injury without skull or facial fracture)

Cognitive Symptom Codes

Cognitive symptoms will be coded using the 799.5x codes. Cognitive deficits should not be coded as 310.1 or 310.8. Memory deficits will be coded with the existing memory code (780.93). Mild cognitive impairment so stated (331.83) cannot be used to code TBI symptoms since it excludes traumatic injuries.

Emotional/ Behavioral Symptom Codes

The 799.2x-series codes allow providers to code emotional/behavioral symptoms without using mental health diagnosis codes; however, these codes do not replace mental health diagnosis codes. Providers should use these codes when they observe the symptoms but no mental health diagnosis is established. In addition, these codes were intended to be used for TBI symptoms, but are not limited to TBI.

Severity of TBI

The below diagnostic criteria does not predict functional or rehabilitative outcome of the patient. The level of injury is based on the status of the patient at the time of injury, based on observable signs such as level of consciousness, post-traumatic amnesia and coma scaling.

Mild	Moderate	Severe
Normal structural imaging	Normal or abnormal structural imaging	Normal or abnormal structural imaging
LOC = 0-30 min	LOC >30 min and < 24 hours	LOC > 24 hrs
AOC = a moment up to 24 hrs	AOC >24 hours. Severity based on other criteria	
PTA = 0-1 day	PTA >1 and <7 days	PTA > 7 days
GCS=13-15	GCS=9-12	GCS=3-8

AOC – Alteration of consciousness/mental state

LOC – Loss of consciousness

PTA – Post-traumatic amnesia

GCS-Glasgow Coma Scale

E&M Procedure Coding for TBI Care

If the psychomotor Neurobehavioral Status Exam is completed, the provider should also utilize the CPT code 96116. This code includes the time for testing, interpreting and a written report must be prepared. Coding is completed in 1-hr units but anything less than an hour is claimed as 1 unit. Documentation must include clinically indicated portions of an 'assessment of thinking, reasoning and judgment (e.g., attention, acquired knowledge, language, memory and problem solving).

ICD9.chrisendres. Retrieved July 7, 2009 from <http://icd9cm.chrisendres.com/index.php>

The Management of Concussion/mTBI Working Group (2009), VA/DoD Clinical Practice Guidelines for Management of Concussion/mTBI. Retrieved July 7, 2009 from <http://www.healthquality.va.gov>

Special Guidance on Traumatic Brain Injury Coding

1/10/2011

Special rules apply to the coding of brain injuries that help to capture data on traumatic brain injury (TBI). This document provides guidance for coding traumatic brain injuries.

In 2009, the DoD and the Department of Veterans Affairs (VA) championed for the establishment of a new series of codes that allows health care providers to code symptoms following TBI as mandated by Congress. On October 1, 2009, the National Center for Health Statistics (NCHS) released the first phase of a series of improvements to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2. These improvements include new codes for signs and symptoms of emotional state (799.2x) such as irritability, emotional lability, and impulsiveness; a new code for TBI screening; and a new series of codes for personal history of TBI. On October 1, 2010, NCHS released the second phase of symptom codes for cognitive deficits (799.5x) such as attention and executive function deficits.

The intent of the new symptoms codes is to allow health care providers to accurately identify the symptoms associated with TBI and further assist in the collection of data on those who have sustained, were diagnosed with, and/or received treatment for TBI.

DoD Definition of Traumatic Brain Injury

The DoD and the VA define TBI as: a traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event:

- Any period of loss of or a decreased level of consciousness (LOC)
- Any loss of memory for events immediately before or after the injury (post-traumatic amnesia [PTA])
- Any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.) (Alteration of consciousness/mental state [AOC])
- Neurological deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia, etc.) that may or may not be transient
- Intracranial lesion.

External forces may include any of the following events: the head being struck by an object, the head striking an object, the brain undergoing an acceleration/deceleration movement without direct external trauma to the head, a foreign body penetrating the brain, forces generated from events such as a blast or explosion, or other forces yet to be defined.

Not all individuals exposed to an external force will sustain a TBI, but any person who has a history of such an event with immediate manifestation of any of the above signs and symptoms can be classified as having had a TBI.

Sequelae of TBI may resolve quickly, within minutes to hours after the neurological event or they may persist longer. Some sequelae of TBI may be permanent. Most signs and symptoms will manifest immediately following the event. However, the onset of other signs and symptoms may be delayed for days to months (e.g., subdural hematoma, seizures, hydrocephalus, spasticity, etc.). Signs and symptoms may occur alone or in varying combinations and may result in functional impairment. These sign and symptoms are not better explained by pre-existing conditions or other medical, neurological, or psychological causes except in cases of an exacerbation of a pre-existing condition.

Severity of Injury

The status of the patient at the time of injury is the basis for rating the severity of the injury. The severity of the injury is based on observable signs such as level of consciousness, post-traumatic amnesia, and imaging. It is important to understand that meeting the below diagnostic criteria does not correlate to nor predict functional or rehabilitative outcome.

Mild	Moderate	Severe
Normal structural imaging	Normal or abnormal structural imaging	Normal or abnormal structural imaging
LOC = 0-30 min	LOC >30 min and < 24 hours	LOC > 24 hrs
AOC = a moment up to 24 hrs	AOC >24 hours. Severity based on other criteria	
PTA = 0-1 day	PTA >1 and <7 days	PTA > 7 days

AOC - Alteration of consciousness/mental state

LOC - Loss of consciousness

PTA - Post-traumatic amnesia

Coding of Traumatic Brain Injuries

Coding Screening Exams (V80.01)

Providers should use V80.01, special screening for TBI, when a Veteran is screened for a TBI regardless of the outcome of the screen (positive screen or negative screen). It is important to note here that a positive screen does not equate to a diagnosis of TBI. A positive TBI screen indicates that the Veteran may have sustained a TBI; however, additional information will need to be gathered through a clinical confirmation examination before a definitive diagnosis of TBI can be made. Veterans who screen positive for TBI and are subsequently diagnosed with a TBI should receive both the TBI screening code (V80.01) and the appropriate 8xx series brain injury code. Diagnostic evaluations or clinical confirmation exams should not be coded with the V80.01 code, as this is strictly a screening code. The V80.01 code should only be used once per injury event. For example, a practitioner may screen a Veteran for a suspected TBI and enter a V80.01 code for this screen. If the same Veteran is involved in a motor vehicle crash several months later, and he/she is screened for suspected TBI, then he/she can receive the V80.01 code again as these two screenings were two separate injury events.

Coding Initial TBI Encounters

An injury code for TBI from the 8xx series is used only once for each TBI sustained and only during the initial encounter. An initial encounter does not refer to the first time the

patient is seen by each provider for that particular TBI. Rather, an initial encounter is defined as the first time the patient is seen by any medical provider for that particular TBI, regardless of when the injury took place. It is still considered an initial encounter even if the patient is evaluated several weeks, months, or years after the injury. Clinical documentation must clearly support that the encounter coded is the initial encounter for that particular injury. A previous TBI diagnosis should be available on the master problem list located in the patient's medical record. If the patient does not have a previously coded 8xx series Brain Injury ICD-9 code for the current TBI, the provider should enter an appropriate 8xx series brain injury ICD-9 code even if the patient denies any current TBI-related symptoms. The 8xx series code is not used at subsequent visits unless a new TBI has occurred. The V80.01 screening code is used at most initial encounters unless the evaluation is a referral for a previous positive screen. In this case, the screening code should not be repeated for the same injury event.

8xx Series Codes

Below is a list of ICD-9 8xx series codes related to TBI diagnosis. Each of the 8xx series codes requires an additional fourth and fifth digit. The fourth digit further describes the 8xx series code. The fifth digit describes the level of consciousness associated with the TBI. In order to ensure the most accurate and appropriate level of coding, documentation must clearly state if there was a loss of consciousness (LOC) due to the injury and, if so, the duration of LOC. If documentation does not clearly define the duration of LOC, then unspecified state of consciousness must be coded.

- 800 - Fracture of vault of skull, includes traumatic brain injury due to fracture of skull
- 801 - Fracture of base of skull, includes traumatic brain injury due to fracture of skull
- 802 - Fracture of face bones, includes traumatic brain injury due to fracture of skull
- 803 - Other and unqualified skull fractures, includes: traumatic brain injury due to fracture of skull
- 804 - Multiple fractures involving skull or face with other bones, includes traumatic brain injury due to fracture of skull
- 850 - Concussion, includes traumatic brain injury without skull fracture
- 851 - Cerebral laceration and contusion, includes traumatic brain injury without skull fracture
- 852 - Subarachnoid, subdural, and extradural hemorrhage, following injury, includes traumatic brain injury without skull fracture
- 853 - Other and unspecified intracranial hemorrhage following injury, includes traumatic brain injury without skull fracture
- 854 - Intracranial injury of other and unspecified nature, includes traumatic brain injury without skull fracture
- 959.9 Injury brain (traumatic)

Order of Coding for Initial Encounter

ICD-9 coding for the initial diagnosing of a TBI injury includes a primary code, and/or TBI screening code (V80.01), and/or E-code (i.e., E979.2 for Terrorism Involving Other Explosions/Fragments).

Primary code: 8xx series

The 8xx series code is listed first as this is the primary code. The appropriate ICD-9 V 15.52_x code is listed second. If the patient already has a brain injury coded for the current TBI, the provider should use the guidelines for subsequent encounters.

Secondary code: V15.52_x code

History codes are acceptable on any medical record regardless of the reason or the visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered. Normally, the V15.52 code is used to identify a personal history of injury with or without a confirmed diagnosis.

Providers should never use the 8xx or V15.52 code unless they have a definitive diagnosis of TBI. One caveat to this is that inpatients without a definitive diagnosis of TBI may be coded using "rule-out", "possible", or "likely". Inpatients should never have an 8xx code entered without a definitive diagnosis of TBI. However, prior to discharge, providers are required to update and finalize the patient's ICD-9 codes and if applicable, include the appropriate 8xx. However, providers are not to use possible, suspected, or other similar rule-out diagnoses when diagnosing and coding outpatient encounters. Providers in the outpatient setting who believe that TBI is possible, likely, or suspected, but lack sufficient evidence or documentation to support the diagnosis, should code the condition(s) to the highest degree of certainty for that encounter, such as symptoms, signs, abnormal test results, or other reason for the visit. In other words, providers should never code an 8xx unless the patient has a definitive diagnosis of TBI.

Coding Subsequent TBI Encounters

All follow-up TBI encounters require a primary code and the appropriate late effect code, as well as all other coding requirements of the ICD-9-CM.

The primary code for all subsequent visits related to the TBI is the patient's chief complaint for the visit (i.e., headache, insomnia, vertigo, etc). The provider should code the remaining symptoms according to the guidelines found in the ICD-9 CM.

The secondary ICD-9-CM code used during subsequent TBI visits is the appropriate late effect code. A late effect is the residual effect (condition produced) after the initial TBI. There are two late effect codes for TBI: 905.0 (late effect of intracranial injury with skull or facial fracture) and 907.0 (late effect of intracranial injury without skull or facial fracture). The late effect code cannot be used for the same encounter that the 8xx series brain injury code is used. The late effect code is used at all subsequent encounters. Late effect symptoms may be apparent early after injury as in the case of cerebrovascular accidents or they may occur months or years later. There is no time limit on how long after injury the late effect code can be used.

The pairing of the symptom code and the late effect code is the ONLY WAY that symptoms can be causally and uniquely associated with TBI and is essential to the accurate classification of TBI.

Exception for Coding Rehabilitation for Subsequent TBI Encounters

The exception to the above rule is when the patient's rehabilitation treatment is the reason for the encounter. Patients who receive inpatient or outpatient rehabilitation will

be coded with the appropriate V57.xx code plus the appropriate symptom code(s) for which the rehabilitation is required (treated) and the late effect code (905.0 or 907.0). The reason for the encounter (rehabilitation) is coded as the primary diagnosis.

Emotional/ Behavioral Symptom Codes

On October 1, 2009, NCHS released the first phase of a series of improvements to the ICD-9-CM, Volumes 1 and 2. Included in these improvements were new codes for emotional/behavioral signs and symptoms that often occur following TBI.

These 799.2x-series ICD-9-CM codes allow providers to code emotional/behavioral symptoms without using mental health diagnoses codes. Providers should use these codes when emotional/behavioral symptoms are observed and a mental health diagnosis is not established or has been ruled out. While these codes are intended to be used for TBI symptoms, they are not limited to TBI.

The new 799.2x ICD-9 codes allow providers to code observed emotional/behavioral symptoms when 1) clinical evaluation excludes a mental health diagnosis and 2) further evaluation or observation is necessary before a mental health diagnosis can be made. If used in the latter context, providers must ensure that if further evaluation reveals another explanation for the emotional/behavioral symptoms, they update the ICD-9 codes to reflect the new information. The 799.2x series codes require the coder to use a fifth digit. The below table list the 799.2x codes with their fifth digits.

It is important to remember that the 799.2x codes do not replace mental health diagnoses codes.

799.2x Emotional / Behavioral Symptoms

ICD-9 Code	Symptom
799.21	Nervousness
799.22	Irritability
799.23	Impulsiveness
799.24	Emotional lability
799.25	Demoralization and apathy
799.29	Other signs and symptoms involving emotional state

Cognitive Symptom Codes

On October 1, 2010, NCHS released the second phase of a series of improvements to the ICD-9-CM, Volumes 1 and 2. Included in these improvements were new codes for cognitive signs and symptoms that often occur following TBI.

These 799.5x-series ICD-9-CM codes allow providers to code cognitive symptoms without using mental health diagnoses codes. Providers should use these codes when cognitive symptoms are observed and a mental health diagnosis is not established or has been ruled out. While these codes are intended to be used for TBI symptoms, they are not limited to TBI.

The new 799.5x ICD-9 codes allow providers to code observed cognitive symptoms when 1) clinical evaluation excludes a mental health diagnosis and 2) further evaluation or observation is necessary before a mental health diagnosis can be made. If used in the latter context, providers must ensure that if further evaluation reveals another explanation for the cognitive symptoms, they update the ICD-9 codes to reflect the new information. The 799.5x series codes require the coder to use a fifth digit. The below table list the 799.5x codes with their fifth digits. Memory deficits will be coded using the existing code 780.93. Cognitive impairment so stated (331.83) cannot be used to code cognitive symptoms due to TBI. Post-concussion syndrome (310.2) may be coded when this condition has been diagnosed by a qualified mental health professional.

It is important to remember that the 799.5x codes do not replace mental health diagnoses codes.

799.5x Cognitive Symptoms

ICD-9 Code	Symptom
799.51	Attention and concentration deficit
799.52	Cognitive communication deficit
799.53	Visuospatial deficit
799.54	Psychomotor deficit
799.55	Frontal lobe and executive function deficit
799.59	Other signs and symptoms involving cognition

Examples of ICD-9 TBI Coding

Initial Encounter

Example 1: A Veteran enrolls for VA care for the first time. The record shows that the Veteran was injured by an improvised explosive device (IED). Fellow soldiers were severely injured in same incident. Veteran denies loss of consciousness (LOC) but reports seeing stars, stumbling around for a few minutes, and cannot account for approximately 15 minutes of activity after the blast.

Primary diagnosis:	850.0	Concussion without LOC
	V80.01	special screening for TBI

Example 2: Veteran presents for evaluation following completion of TBI Screening with positive findings. Review of the record reveals that the Veteran received evaluation six months ago in theater following a motor vehicle crash with documentation of right arm fracture and facial contusions. Although there was no documentation that the Veteran received evaluation for TBI, he cannot recall the events that occurred immediately after the accident. Documentation of follow-up visits in theater reveals complaints of headache, but no documentation of treatment for the headache. Today's visit reveals persistent headaches since the accident (no previous history of headaches).

Primary diagnosis:	850.0	Concussion without LOC
	784.0	Headache

* TBI screening code V80.01 would not be applied to this visit as this code would be applied at TBI screening.

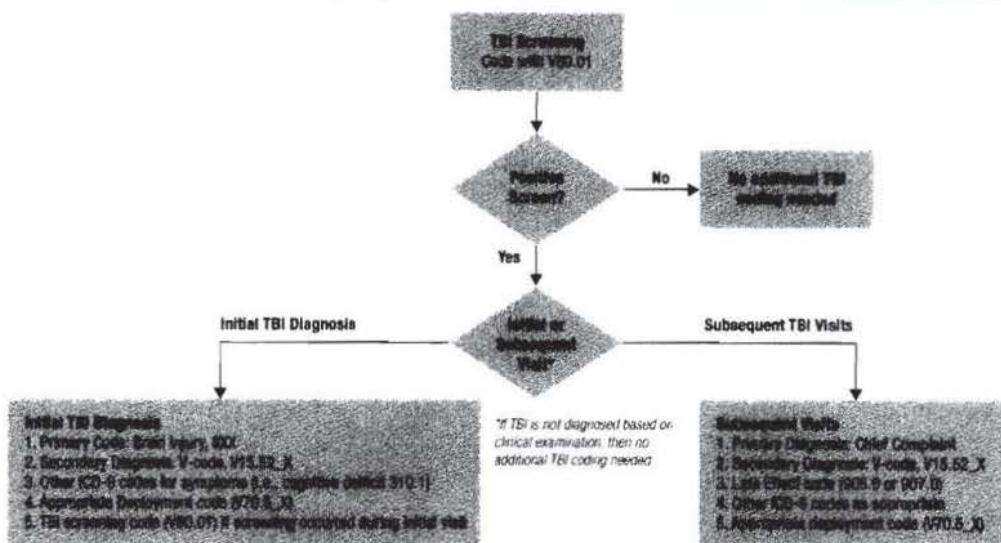
Subsequent Encounters

Example 1: Veteran presents to her VA facility after returning home from Iraq complaining of headaches that began shortly after she was exposed to an improvised explosive device (IED) blast two weeks ago. The provider reviews notes and finds a note written immediately after the injury documenting the following: a description of the injury event, alteration of consciousness of less than 5 minutes, no other AOC, no PTA, and ICD-9 code 850.0. The provider determines that the present complaint of headache may be related to the previously diagnosed TBI.

Primary diagnosis:	784.0	Headache
	907.0	Late effect of intracranial injury <u>without</u> skull or facial fracture.

800 804 & 850 854 Series Codes					
Series Code	Description				
Fractures of vault of skull - require a fourth and fifth digit					
Fractures of base of skull - require a fourth and fifth digit					
Fracture of face bones - require a fourth and fifth digit					
Other and unqualified skull fractures - require a fourth and fifth digit					
Multiple fractures involving skull or face with other bones - require a fourth and fifth digit					
Concussion - require a fourth and fifth digit					
Cerebral laceration and contusion - require a fourth and fifth digit					
Subarachnoid, subdural, and extradural hemorrhage, following injury - require a fourth and fifth digit					
Other and unspecified intracranial hemorrhages following injury - require a fourth and fifth digit					
Intracranial injuries of other and unspecified nature - require a fourth and fifth digit					
V-Code must be used with all TBI encounters	Injury Related to Global War on Terrorism	Level of Severity			
		Unknown	Mild	Moderate	Severe
Personal history of traumatic brain injury NOT otherwise specified					
Yes	X				
Yes		X			
Yes			X		
Yes				X	
Yes					X
No	X				
No		X			
No			X		
No				X	
Unknown	X				
Unknown		X			
Unknown			X		
Unknown				X	
Unknown					X
Late Effect Code (must be used with all follow up TBI encounters)					
Late effect of intracranial injury with skull or facial fracture					
Late effect of intracranial injury without skull or facial fracture					
Common Symptoms Associated with TBI			Emotional/Behavioral Symptom Codes		
Code	Description	Series Code	Description		
Hearing			Nervousness		
	Hearing Loss, Unspecified		Irritability		
	Hyperacusis		Impulsiveness		
	Tinnitus		Emotional Lability		
Neurologic			Demoralization and Apathy		
	Dizziness, Lightheadedness		Other Signs and Symptoms Involving Emotional State		
	Headache				
	Memory Loss, NOS				
	Vertigo				
Psychiatric					
	Acute Stress Reaction, Unspecified				
	Anxiety/Irritability				
	Depression				
Sleep					
	Sleep disturbance				
	Insomnia				
Vision					
	Blurred Vision, NOS				
	Photophobia				
Other/General					
	Malaise and Fatigue				
	Nausea				
F&M Coding for TBI Care					
Series Code	Description				
	New Outpatient-level 3				
	New Outpatient-level 4				
	Established Outpatient-level 3				
	Established Outpatient-level 4				
	Procedure Code for TBI Care				
	Neurobehavioral status exam				
TBI Screening Code					
	Special Screening for TBI				

DoD ICD-9 CM CODING GUIDANCE FOR TRAUMATIC BRAIN INJURY



DoD Definition of TBI

A traumatically induced structural injury and/or physiological disruption of brain function as a result of external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event:

- Any period of loss of or a decreased level of consciousness;
- Any loss of memory for events immediately before or after the injury;
- Any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.);
- Neurological deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia, etc.) that may or may not be transient;
- Intracranial lesion.

External forces may include any of the following events: the head being struck by an object, the head striking an object, the brain undergoing an acceleration/deceleration movement without direct external trauma to the head, a foreign body penetrating the brain, forces generated from events such as blast or explosion, or other force yet to be defined. (Department of Defense, 2007)

Severity of TBI

The level of injury is based on the status of the patient at the time of injury based on observable signs. Severity of injury does not predict functional or rehabilitative outcome of the patient.

Mild	Moderate	Severe
Normal structural imaging	Normal or abnormal structural imaging	Normal or abnormal structural imaging
LOC = 0-30 min	LOC > 30 min and < 24 hours	LOC > 24 hrs
AOC = a moment up to 24 hrs	AOC > 24 hours. Severity based on other criteria	
PTA = 0-1 day	PTA > 1 and < 7 days	PTA > 7 days

AOC - Alteration of consciousness/mental state

LOC - Loss of consciousness

PTA - Post-traumatic amnesia

Look Before You Code

Prior to using a TBI ICD-9 code, the provider should ensure that the patient does not have an existing TBI diagnosis code for the current injury. Previous TBI diagnoses are recorded in the problem list. In the event the patient does not have a previously coded TBI for the present injury, an appropriate provider should enter the correct 800 series ICD-9 code and the correct V15.52_X code during the visit. This coding should occur even if the patient denies TBI-related symptoms.

Personal History of TBI Codes & Late Effect Codes

Providers must always utilize the appropriate personal history V15.52_X code with any diagnosed TBI encounter, initial or follow-up. This is crucial for TBI surveillance purposes. In addition, all follow-up TBI encounters must be coded with one of two late effect codes: 905.0 (late effect of intracranial injury with skull or facial fracture) or 907.0 (late effect of intracranial injury without skull or facial fracture).

Procedure Coding for TBI Care

The CPT code 96116 is used if the Psychomotor Neurobehavioral Status Exam is completed. This code includes the time for testing, interpreting and preparing the report. While many clinicians may be able to complete this within minutes during a quick office screen, coding is completed in one hour units. Anything less than one hour is claimed as 1 unit. Documentation must include clinically indicated portions of an assessment of thinking, reasoning and judgment (e.g., attention, acquired knowledge, language, memory and problem solving). The areas most often affected by TBI include attention, memory and problem solving so these areas should be screened if there are cognitive complaints. Other areas may be assessed as clinically indicated. This procedure may be completed in follow-up visits as long as the documentation is supportive (history and documented screening examination).

Emotional/ Behavioral Symptom Codes

The 799-series codes allow providers to code emotional/behavioral symptoms without using mental health diagnosis codes. These codes do not replace mental health diagnosis codes. Providers should use these codes when they observe the symptoms but a mental health diagnosis is not established. While these codes are intended to be used for TBI symptoms, they are not limited to TBI.



Fact Sheet

Interim Coding Guidance for Traumatic Brain Injury

Updated September 2009

IMPORTANT NOTE: This interim guidance is only to be used until more appropriate codes are available. This Fact sheet will be updated as needed. This updated Fact Sheet reflects use of codes effective 10/1/2009, ALL PREVIOUS VERSIONS OF THIS FACT SHEET ARE RESCINDED.

BACKGROUND: VHA has a need, to the best of its ability, to uniquely identify and report on Veterans with Traumatic Brain Injury (TBI) the severity of the TBI and any late effects from such injuries. VHA in conjunction with DoD developed Phase I TBI codes that are effective 10/01/2009. These codes are part of a phased approach to new code development to more accurately capture and reflect TBI and its effects.

CODING GUIDANCE: An appropriate injury code from the 8xx series will be coded ONCE, at the time of the **initial** encounter. An initial encounter is defined as the first time the patient is seen for the injury, regardless of when the injury took place. If an injury occurred in the past several months or even years but the patient has never sought treatment for the injury previously, the first time the patient is SEEN for the injury is considered the initial treatment. If a practitioner is seeing a patient for treatment of an injury for the first time, and the treatment for the injury has previously been provided by any other medical professional, it is NOT an initial encounter for that injury. In order to code an initial TBI injury, documentation must clearly state that the encounter being coded is the INITIAL or first encounter for treatment of the TBI.

EXAMPLE: Veteran is seen for the first time at a VA facility for memory problems. During the history, the practitioner determines on the basis of Veteran's self-report that there was brief loss of consciousness less than 30 minutes due to an improvised explosive device (IED) blast. The Veteran reports that he has never sought treatment for the condition, which is causing significant problems at work. The practitioner codes mild TBI (850.11) and codes the initial encounter for memory problems (310.1) due to TBI. TBI may be associated with skull fracture (800-801 or 803-804). TBI may also be associated with intracranial injury without skull fracture (850-854). Severity is stratified according to loss of consciousness. A fifth digit will be required to indicate length of time the Veteran was unconscious. In order to ensure the most accurate and appropriate level of coding, documentation must clearly state if there was a loss of consciousness (LOC) due to the injury and the duration of the LOC. If documentation does not clearly define the LOC then unspecified state of consciousness must be coded. When appropriate an E code from the E99x series may be assigned. Please refer to your Health Information Management Coding Department for further guidance on E codes.

CODING FOLLOW UP CARE: For follow up visits for symptoms directly related to a previous TBI, the symptom code(s) that best represents the patient's symptom(s) (i.e., headache, insomnia, vertigo) are coded, followed by the appropriate late effect code (905.0 or 907.0). Late effects include any symptom or sequelae of the injury specified as such, which may occur *at any time after the onset of the injury*.

For traumatic brain injury patients who receive inpatient or outpatient rehabilitation, the first-entered diagnosis is the purpose of the encounter from the V57.x series, followed by the late effect (905.0 or 907.0) Use additional codes for the specific residuals.

USE of V15.52 CODE: V15.52 Personal history of traumatic brain injury was developed to indicate that previous TBI occurred and may impact current care. The V15.52 code is not used in conjunction with the late effect codes; rather the V code is used when no other code is available to reflect a previous TBI.

USE of V80.01 CODE: Special screening for traumatic brain injury is used when a suspected TBI is ruled out or not found. This code is only when a Veteran is screened for effects of a TBI and none are found.

**VA
ICD-9 CM
CODING GUIDANCE
For
TRAUMATIC BRAIN
INJURY
(TBI)**

INITIAL TBI DIAGNOSIS

Initial TBI Diagnosis

1. Primary Code: Brain Injury, 800 series
2. Other ICD-9 codes for symptoms (i.e., cognitive deficit 310.1)

Diagnoses of TBI

NO

Screening for
TBI
ICD-9 codes (V80.01)

Initial Or Subsequent Visit

SUBSEQUENT TBI VISITS

ASSOCIATING SYMPTOMS TO TBI

1. Primary Diagnosis: Chief Complaint
 2. Secondary Diagnosis: Late Effect code (905.0 or 907.0)
 3. Other pertinent ICD-9 codes as appropriate
- OR**

REHABILITATION

1. Primary Diagnosis: V57 code (rehab only)
2. Secondary Diagnosis: Condition treated
3. Secondary Diagnosis: Late Effect code (905.0 or 907.0)

OR

RELEVANT HISTORY OF TBI (NO CURRENT SYMPTOMS)

1. Pertinent ICD-9 codes as appropriate
2. V15.52

Look Before You Code



Before assigning a primary diagnosis for an initial TBI, please review all existing documentation, including that from outside sources, to ensure that a previous TBI code has not been assigned.

Late Effect Code

All follow-up treatment for TBI symptoms must include the code for the signs or symptoms associated with the previous TBI IN ADDITION TO one of two codes to reflect the current symptoms are due to a late effect of a previous injury 905.0 (late effect of intracranial injury with skull or facial fracture) or 907.0 (late effect of intracranial injury without skull or facial fracture).

Cognitive Symptom Codes

Cognitive symptom codes are currently being explored and will be addressed in the future. In the interim, providers should continue to document Cognitive deficits as 310.1 and memory deficits as 310.8. It is recommended that 331.83 (mild cognitive impairment) not be used since it excludes traumatic injuries and that 780.93 (memory loss NOS) not be used.

Emotional/ Behavioral Symptom Codes

The 799-series codes allow providers to code emotional/behavioral symptoms without using mental health diagnosis codes; however, these codes do not replace mental health diagnosis codes. Providers should use these codes when they observe the symptoms but no mental health diagnosis is established. In addition, these codes were intended to be used for TBI symptoms, but are not limited to TBI.

Severity of TBI

The below diagnostic criteria does not predict functional or rehabilitative outcome of the patient. The level of injury is based on the status of the patient at the time of injury, based on observable signs such as level of consciousness, post-traumatic amnesia and coma scaling.

Mild	Moderate	Severe
Normal structural imaging	Normal or abnormal structural imaging	Normal or abnormal structural imaging
LOC = 0-30 min	LOC >30 min and < 24 hours	LOC > 24 hrs
AOC = a moment up to 24 hrs	AOC >24 hours. Severity based on other criteria	
PTA = 0-1 day	PTA >1 and <7 days	PTA > 7 days
GCS=13-15	GCS=9-12	GCS=3-8

AOC – Alteration of consciousness/mental state

LOC – Loss of consciousness

PTA – Post-traumatic amnesia

GCS-Glasgow Coma Scale

E&M Procedure Coding for TBI Care

If the psychomotor Neurobehavioral Status Exam is completed, the provider should also utilize the CPT code 96116. This code includes the time for testing, interpreting and a written report must be prepared. Coding is completed in 1-hr units but anything less than an hour is claimed as 1 unit. Documentation must include clinically indicated portions of an 'assessment of thinking, reasoning and judgment (e.g., attention, acquired knowledge, language, memory and problem solving).

ICD9.chrisendres. Retrieved July 7, 2009 from <http://icd9cm.chrisendres.com/index.php>

The Management of Concussion/mTBI Working Group (2009). VA/DOD Clinical Practice Guidelines for Management of Concussion/mTBI. Retrieved July 7, 2009 from <http://www.healthquality.va.gov>

Table 3 - BRCs Accepting DoD Referrals

Blind Rehabilitation Centers	Address	Telephone
Charlie Norwood VA Medical Center (324)	One Freedom Way Augusta, GA 30904-6285	706-733-0188 x6660 POC: By Title/ Program AO for all below
Birmingham VA Medical Center (124)	700 South 19th Street Birmingham, AL 35233	205-933-8101
Edward Hines, Jr. VA Medical Center (124)	Fifth Avenue and Roosevelt Rd Hines, IL 60141-5000	708-202-8387 x22112
Central Texas VA Health Care System Blind Rehabilitation Center	1901 Veterans Memorial Dr Temple, TX 76504 4800 Memorial Dr Waco, TX 76711	254-297-3755 254-297-3755
San Juan VA Medical Center (124)	10 Casia Street San Juan, PR 0092 1-3201	787-641-8325
Southern Arizona VA Health Care System (3-124)	3601 South 6th Ave Tucson, AZ 85723	520-629-4643
VA Connecticut Health Care System (124)	West Haven Campus 950 Campbell Ave West Haven, CT 06516	203-932-5711 x2247
VA Palo Alto HCS (124)	3801 Miranda Ave Palo Alto, CA 94304	650-493-5000 x64218
VA Puget Sound I-ICS (124) American Lake Division	1660 South Columbian Way Seattle, WA 98108-1597 (A-i 12-BRC) 9600 Veterans Dr Tacoma, WA 98493	253-583-1203 253-983-1299
West Palm Beach VA Medical Center (124)	7305 North Military Tr West Palm Beach, FL 334 10-6400	561-422-8425



Department of Defense Coding Guidance for Traumatic Brain Injury Fact Sheet

IMPORTANT NOTE: This guidance is being submitted to the Unified Biostatistical Utility for inclusion in the Coding Guidebook. This Fact Sheet will be updated as needed.

CODING INITIAL ENCOUNTER FOR TBI: The initial visit is coded using an 8XX series codes as the primary code followed by the appropriate TBI V code, any symptom codes and the appropriate deployment status code. An injury code for TBI from the 8XX series is used only once and is used for the initial encounter. An initial encounter does not refer to the first time the patient is seen by each clinician for that particular TBI. Rather, an initial encounter is defined as the first time the patient is seen by any medical professional for the TBI, regardless of when the injury took place even if it occurred several weeks, months or years prior to the encounter. Clinical documentation must clearly indicate that the encounter coded is the initial encounter for that particular injury.

TBI may be associated with skull fracture (800-801 or 803-804) or without skull fracture (850-854). A fourth digit is required that further describes the 8XX series codes. A fifth digit is required to describe the level of consciousness associated with the TBI. In order to ensure the most accurate and appropriate level of coding, documentation must clearly state if there was a loss of consciousness (LOC) due to the injury and, if so, the duration of LOC. If documentation does not clearly define the duration of LOC, then unspecified state of consciousness must be coded.

CODING SUBSEQUENT ENCOUNTERS FOR TBI CARE: Subsequent visits for the injury are coded using symptom codes that best represent the patient's presenting complaint (i.e. headache, insomnia, vertigo) as the primary code. The primary code is then followed by the appropriate personal history of TBI V code (V15.52_X), the appropriate late effect code (905.0 or 907.0) and the appropriate deployment status code.

PERSONAL HISTORY OF INJURY CODE: V15.52_X codes (personal history of TBI) are used to assist the Department of Defense in tracking TBI occurrences. Therefore, the appropriate V15.52_X code should be utilized at all encounters associated with the TBI.

LATE EFFECT CODE: A late effect code is used for all TBI follow-up visits. There are two late effect codes: 905.0 (late effect of intracranial injury with skull or facial fracture) and 907.0 (late effect of intracranial injury without skull or facial fracture).

DEPLOYMENT STATUS CODE: Visits are coded according to the patient's deployment status, if applicable: V70.5_6 (post-deployment encounter) or V70.5_5 (during deployment encounter).

TBI SCREENING CODE: Code V80.01 should be used if TBI screening occurs at a visit. Reminder: A TBI diagnosis code should not be entered for a positive screen since a positive TBI screen does not indicate a TBI diagnosis. A TBI diagnosis code can only be entered for the encounter at which the diagnosis is made.

INPATIENT/OUTPATIENT REHABILITATION: The first code entered for patients who are receiving inpatient or outpatient rehabilitation following TBI is taken from the V57.XX series. This code is then followed by the primary symptom code, the late effect code (905.0 or 907.0) and the appropriate personal history of TBI code (V15.52_X). Use additional codes for other symptoms as appropriate.

E-CODE: An E-code may be assigned when appropriate (i.e., E979.2 (Terrorism Involving Other Explosions/Fragments)). Please refer to your Health Information Management Coding Department for further guidance on E-codes.

EXAMPLE: Service member (SM) seen for the first time at a military treatment facility for complaints of memory problems several weeks after returning home from deployment. The patient reports that he was part of a convoy that was hit by an improvised explosive device (IED) blast and while he didn't sustain any physical injuries, he reports that he was unconscious for approximately three minutes. The SM reports that he has never sought treatment for his complaint of difficulty remembering things which are now causing significant difficulty at work. The practitioner ensures documentation that this visit was an initial encounter for TBI as the patient was never seen by medical for the incident he described. The practitioner codes this initial encounter as:

850.11: Concussion with LOC of 30 minutes or less
V15.52_2: Injury related to Global War on Terrorism, Mild
780.93: Memory Loss, NOS
V80.01: TBI Screening
V70.5_6: Post-deployment encounter

Reference: Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines, Version 1.0, Unified Biostatistical Utility, 2005
Appendix G: Special Guidance on Traumatic Brain Injury Coding, 2009

800-804 & 850-854 Series Codes

Series Code	Description
800	Fractures of vault of skull - require a fourth and fifth digit
801	Fractures of base of skull - require a fourth and fifth digit
802	Fracture of face bones - require a fourth and fifth digit
803	Other and unqualified skull fractures - require a fourth and fifth digit
804	Multiple fractures involving skull or face with other bones - require a fourth and fifth digit
850	Concussion - require a fourth and fifth digit
851	Cerebral laceration and contusion - require a fourth and fifth digit
852	Subarachnoid, subdural, and extradural hemorrhage, following injury - require a fourth and fifth digit
853	Other and unspecified intracranial hemorrhages following injury - require a fourth and fifth digit
854	Intracranial injuries of other and unspecified nature - require a fourth and fifth digit

V-Code (must be used with all TBI encounters)	Injury Related to Global War on Terrorism	Level of Severity				
		Unknown	Mild	Moderate	Severe	Penetrating
V15.52 0	Personal history of traumatic brain injury NOT otherwise specified					
V15.52 1	Yes	X				
V15.52 2	Yes		X			
V15.52 3	Yes			X		
V15.52 4	Yes				X	
V15.52 5	Yes					X
V15.52 6	No	X				
V15.52 7	No		X			
V15.52 8	No			X		
V15.52 9	No				X	
V15.52 A	No					X
V15.52 B	Unknown	X				
V15.52 C	Unknown		X			
V15.52 D	Unknown			X		
V15.52 E	Unknown				X	
V15.52 F	Unknown					X

Late Effect Code (must be used with all follow-up TBI encounters)

905.0	Late effect of intracranial injury with skull or facial fracture
907.0	Late effect of intracranial injury without skull or facial fracture

Common Symptoms Associated with TBI	
Code	Description
Hearing	
389.9	Hearing Loss, Unspecified
388.42	Hyperacusis
388.3	Tinnitus
Neurologic	
780.4	Dizziness, Lightheadedness
784.0	Headache
780.93	Memory Loss, NOS
438.85	Vertigo
Psychiatric	
308.9	Acute Stress Reaction, Unspecified
300	Anxiety / Irritability
311	Depression
Sleep	
780.5	Sleep disturbance
780.52	Insomnia
Vision	
368.8	Blurred Vision, NOS
368.13	Photophobia
Other/General	
780.7	Malaise and Fatigue
787.02	Nausea

Emotional/ Behavioral Symptom Codes	
Series Code	Description
799.21	Nervousness
799.22	Irritability
799.23	Impulsiveness
799.24	Emotional Lability
799.25	Demoralization and Apathy
799.29	Other Signs and Symptoms Involving Emotional State

E&M Coding for TBI Care	
Series Code	Description
99203	New Outpatient-level 3
99204	New Outpatient-level 4
99213	Established Outpatient-level 3
99214	Established Outpatient-level 4

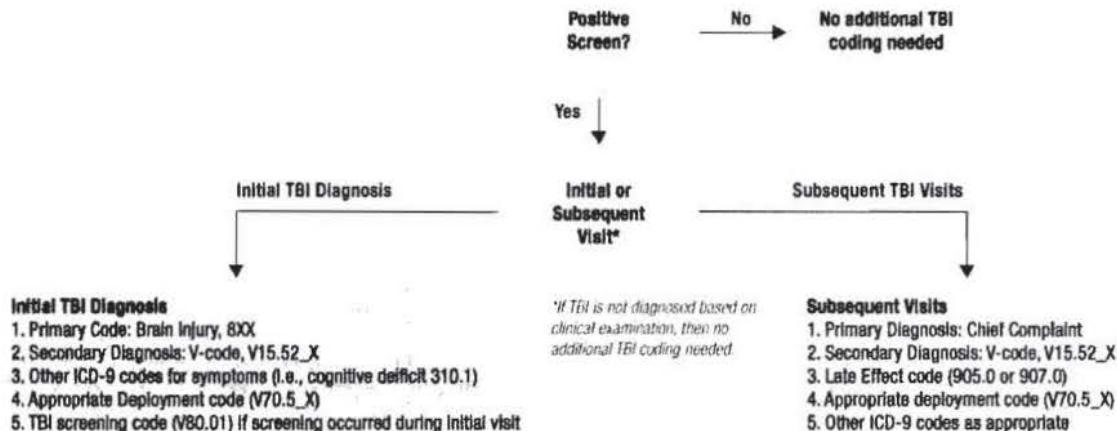
Procedure Code for TBI Care	
Series Code	Description
96116	Neurobehavioral status exam

TBI Screening Code	
Series Code	Description
V80.01	Special Screening for TBI

DoD ICD-9 CM CODING GUIDANCE FOR TRAUMATIC BRAIN INJURY



TBI Screening Code with V80.01



DoD Definition of TBI

A traumatically induced structural injury and/or physiological disruption of brain function as a result of external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event:

- Any period of loss of or a decreased level of consciousness;
- Any loss of memory for events immediately before or after the injury;
- Any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.);
- Neurological deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia, etc.) that may or may not be transient;
- Intracranial lesion.

External forces may include any of the following events: the head being struck by an object, the head striking an object, the brain undergoing an acceleration/deceleration movement without direct external trauma to the head, a foreign body penetrating the brain, forces generated from events such as blast or explosion, or other force yet to be defined. (Department of Defense, 2007)

Severity of TBI

The level of injury is based on the status of the patient at the time of injury based on observable signs. Severity of injury does not predict functional or rehabilitative outcome of the patient.

Mild	Moderate	Severe
Normal structural imaging	Normal or abnormal structural imaging	Normal or abnormal structural imaging
LOC = 0-30 min	LOC >30 min and < 24 hours	LOC > 24 hrs
AOC = a moment up to 24 hrs	AOC >24 hours. Severity based on other criteria	
PTA = 0-1 day	PTA >1 and <7 days	PTA > 7 days

AOC – Alteration of consciousness/mental state

LOC – Loss of consciousness

PTA – Post-traumatic amnesia

Look Before You Code

Prior to using a TBI ICD-9 code, the provider should ensure that the patient does not have an existing TBI diagnosis code for the current injury. Previous TBI diagnoses are recorded in the problem list. In the event the patient does not have a previously coded TBI for the present injury, an appropriate provider should enter the correct 800 series ICD-9 code and the correct V15.52_X code during the visit. This coding should occur even if the patient denies TBI-related symptoms.

Procedure Coding for TBI Care

The CPT code 96116 is used if the Psychomotor Neurobehavioral Status Exam is completed. This code includes the time for testing, interpreting and preparing the report. While many clinicians may be able to complete this within minutes during a quick office screen, coding is completed in one hour units. Anything less than one hour is claimed as 1 unit. Documentation must include clinically indicated portions of an assessment of thinking, reasoning and judgment (e.g., attention, acquired knowledge, language, memory and problem solving). The areas most often affected by TBI include attention, memory and problem solving so these areas should be screened if there are cognitive complaints. Other areas may be assessed as clinically indicated. This procedure may be completed in follow-up visits as long as the documentation is supportive (history and documented screening examination).

Personal History of TBI Codes & Late Effect Codes

Providers must always utilize the appropriate personal history V15.52_X code with any diagnosed TBI encounter, initial or follow-up. This is crucial for TBI surveillance purposes. In addition, all follow-up TBI encounters must be coded with one of two late effect codes: 905.0 (late effect of intracranial injury with skull or facial fracture) or 907.0 (late effect of intracranial injury without skull or facial fracture).

Emotional/ Behavioral Symptom Codes

The 799-series codes allow providers to code emotional/behavioral symptoms without using mental health diagnosis codes. These codes do not replace mental health diagnosis codes. Providers should use these codes when they observe the symptoms but a mental health diagnosis is not established. While these codes are intended to be used for TBI symptoms, they are not limited to TBI.