

Appendix G: Special Guidance on Traumatic Brain Injury Coding

Special rules apply to the coding of brain injuries, specifically to Department of Defense (DOD) extenders for capturing data on traumatic brain injury (TBI). This guidance is intended for coding traumatic brain injury (TBI) occurring both in theater and at all military treatment facilities (MTFs).

TBI is coded based on documentation contained within the medical record and in accordance with MHS and ICD-9-CM coding guidelines. In all cases of TBI, at least two codes are necessary to capture the required elements. Other codes may apply to encounters and should be used in accordance with general coding guidance (i.e. deployment codes, E codes).

Initial Coding of Acute TBI and TBI Symptoms. On the initial visit for the TBI at an MTF, the first-entered or principal/primary diagnostic code is the brain injury code (generally a code from the 800-801, 803-804, or 850-854 series). Intracranial injury (e.g. concussion) will likely be entered very early in the triage or care process. The code is not entered subsequently since repeated entries will skew TBI statistics. If there is no TBI diagnosis, the DoD practitioner must make the diagnosis on the basis of available information as soon as it is manifested. The secondary code is the appropriate TBI V-code (V15.59_x).

In the MHS to track TBI occurrences we utilize the V15.59_x (history of TBI) along with the acute TBI codes, late effect codes, and/or symptomology codes associated with a TBI.

All Intracranial injuries (TBI) are stratified by loss of consciousness. A fifth digit may be required to specify the level of injury. Intracranial injuries are broadly grouped into those injuries associated with skull fracture (800-801, 803-804) and those injuries not associated with skull fracture (850-854). Intracranial injuries not associated with skull fracture are further classified into those injuries not associated with specific causes (850 and 854 series) and those injuries associated with known causes (851-853 series), e.g. lacerations, contusions, and hemorrhages.

Subsequent Coding of Acute TBI and TBI Symptoms. On follow up visits, the first-entered or principal/primary diagnosis is the symptom that best represents the patient's chief complaint or symptom(s) (i.e. headache, insomnia, vertigo). For patients who have more than one symptom, code all symptoms that are present, that may influence health status, or are relevant to clinician decisions. The exception to this rule is when patients are seen for rehabilitation. In such cases, the appropriate V-code (see V57.x) is the first-entered or principal/primary diagnosis. Few patients will meet the diagnostic criteria for post-concussion Syndrome (310.2); ensure the diagnostic criteria are met prior to using this code. See example 4.

Late Effects. A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. The acute phase is not defined and is left to clinical judgment. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury. The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect.

Coding of late effects requires three codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The TBI V code is sequenced second, followed by the late effect code. See example 5.

Late effects of intracranial injury will be coded according to the presence of skull fracture. Intracranial with mention of skull fracture will be coded as 905.0. Intracranial injury without skull fracture will be coded as 907.0.

Guidance of Coding Acute and Persistent (Late Effect) Symptoms. There is no accepted standard for when TBI symptoms cease to be acute and become persistent. The following guidance is recommended for documentation and coding consistency:

- Acute—symptoms observed up to 7 days.
- Sub-acute—symptoms observed 8-90 days.
- Chronic—symptoms observed >90 days.

These criteria are consistent with DSM-IV. The term sub-acute and chronic are not defined in ICD-9-CM but should be coded as late effects (i.e. acute rules: up to 7 day; late effect rules: >7 days. These timelines are suggestions only and may be modified on the basis of unique circumstances and clinical judgment. Provider documentation should describe the condition as “late, chronic, or due to TBI, following TBI” in order to substantiate late effect ICD-9-CM codes.

TBI V15.59_x Extenders. V15.59_x coding is mandatory. V15.59_x captures personal history of TBI. The code has been adapted for use in DoD to capture additional detail on nature of injury (penetrating and non-penetrating), severity of injury (e.g. loss of consciousness, post-traumatic amnesia, and Glasgow Coma Scale), and GWOT status. There are only five codes based on injury severity (mild, moderate, severe, penetrating and unknown). The V15.59_x extender code sequence repeats to capture GWOT, non-GWOT, and UNKNOWN if GWOT status. The TBI V-codes became available 1 Oct 07.

History codes are acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

Acute Stage. The acute stage of TBI is not defined. ICD-9-CM coding rules do not allow acute symptoms to be associated with TBI by coding brain injury codes. Coding V15.59_x solves this problem of associating acute symptoms with TBI. V15.59_x is coded with any symptom or symptoms that are present or are related to a TBI event.

Late Effects. For late effects (persistent symptoms or residuals), TBI is coded with the symptom at each episode of care to show the association. The condition or nature of the late effect is sequenced first. The TBI V code is sequenced second, followed by the late effect code.

Coding V15.59_x Extenders When Diagnosis is Certain. If a patient has a confirmed injury to the brain, such as a penetrating head wound, concussion, and/or is suffering from post-concussion syndrome, then the V15.59_x extender code with the highest degree of certainty will be coded. Appropriate non-specific extenders will be assigned

(e.g. V15.59_1, V15.59_6) when there is insufficient documentation to arrive a certain diagnosis.

Coding V15.59_x Extenders When Diagnosis is Uncertain. Normally, this code is used to identify a personal history of injury with or without a confirmed diagnosis. Since DoD is using the code for a different purpose, the guidance herein differs from official ICD-9 guidance.

Inpatients. An acute TBI may be documented and coded as a “rule out, possible, likely” diagnosis on an inpatient. V15.59_x should never be coded when there is an uncertain TBI diagnosis. If a diagnosis of TBI is confirmed prior to discharge, then the TBI diagnosis and V15.59_x should be coded.

Outpatients. Outpatients are never coded with probable diagnosis. V15.59_x should never be coded when there is an uncertain TBI diagnosis. In those instances where a patient is treated as an outpatient and the provider believes there is a possible, likely, or suspected TBI, outpatient coding rules require that diagnoses not be documented as “probable”, “suspected,” “questionable,” “rule out,” or other similar terms indicating uncertainty. Rather, the provider codes the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit. This guidance differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

Coding V15.59_x Extenders When Treatment is Reason for the Encounter. TBI patients who receive inpatient or outpatient rehabilitation will be coded with the appropriate "V57.xx" code with a code for acute symptoms or late effects (905.0 or 907.0) being treated. The reason for the encounter (treatment) is always coded as the first-entered or principal/ primary diagnosis. A patient with a history of traumatic brain injury is coded with V15.59_x even if no residuals are present because such information may be relevant to care decisions.

Sequencing of Codes. When an individual has a confirmed or suspected TBI, the injury or primary symptom code is in the first field and the V15.59_x code is in the secondary diagnosis field:

SIDR - position 2 – 20 on the standard inpatient data record

SADR - position 2 – 4 on the standard ambulatory data record

Ensure that any deployment codes and E codes appear in positions 3-4 in the SADR if they apply.

Example 1: A soldier presents to the BAS after convoy hit by IED per CENTCOM policy. Other soldiers severely injured in same incident. Soldier denies LOC, but reports seeing stars, stumbling around for a few minutes, and he cannot account for approximately 15 minutes of activity after the explosion. At time of evaluation, soldier is asymptomatic and MACE score 30/30.

Primary diagnosis: 850.0 (Concussion without LOC)

Secondary diagnoses: V15.59_2 (Personal History of TBI, GWOT Related, Mild (Glasgow Coma Scale 13-15), LOC<1hr, Post Trauma Amnesia<24hr)

E979.2 (Terrorism Involving Other Explosions/Fragments)

V70.5_5 (During deployment encounter)

Example 2: A soldier presents to the MTF stating she is suffering from headaches which date back to an explosion occurring in Iraq two weeks ago. Provider reviews AHLTA notes and finds a note written immediately after the injury that document the injury event associated with an alteration of consciousness coded with 850.0. The provider determines that the complaints are acute.

Primary diagnosis: 784.0 (Headache)

Secondary diagnosis: V15.59_2 (Personal History of TBI, GWOT Related Mild (Glasgow Coma Scale 13-15), LOC<1hr, Post Trauma Amnesia<24hr)

V70.5_6 (Post-deployment encounter)

Note: V15.59_x associates the acute symptom (headache) with TBI.

Example 3: A soldier presents to the clinic for evaluation of persistent headaches after she answered yes to one of the TBI questions on the PDHA. Review of her AHLTA notes reveals post-MVC evaluation in theater with documentation of right arm fracture and facial contusions 6 months ago, but no documentation of TBI evaluation, no MACE, and no TBI diagnoses coded. Follow up visits indicate complaint of headaches, but no documentation of treatment. Patient interview reveals a history of headaches, tinnitus, intermittent dizziness, and blurred vision since the accident. She also had grogginess and poor recall of events for a few hours after the crash.

Primary diagnosis: 784.0 (Headache)

Secondary diagnoses: V15.59_2 (Personal History of TBI, GWOT Related, Mild (Glasgow Coma Scale 13-15), LOC<1hr, Post Trauma Amnesia<24hr)

V70.5_6 (Post deployment encounter)

Example 4: A soldier presents to the MTF clinic three months after discharge. He complains of memory problems and slowed thinking, sleep disturbances, headaches, personality changes, and ringing in his ears. He has a history of a motor vehicle crash while deployed in Afghanistan where he struck his head on the steering wheel with loss of consciousness for ten minutes. The provider determines that the patient has cognitive deficits, headaches, personality changes, and tinnitus, and that these diagnoses are related to a TBI injury occurring during his deployment to Afghanistan and documented in his medical record as 850.11. The presentation conforms to criteria for post-concussion syndrome: (a) history of TBI; (b) evidence from neurobehavioral testing of cognitive deficits in attention and/or memory; (c) three or more of the following symptoms that appear after injury and persist for three months or more: fatigue, sleep disturbance, headaches, vertigo or dizziness, irritability, apathy or affective disturbance, or personality changes; (d) symptoms in (b) and (c) begin or worsen after injury; (e)

interference with social or occupational functioning; and (f) symptoms are not consistent with dementia and are not better explained by other mental disorders. Symptom onset or course must be contiguous with TBI, distinguishable from pre-existing conditions, and of a minimum duration. The provider determined that this patient met the diagnostic criteria for post-concussion syndrome and documented the diagnosis as Post-concussion Syndrome. The encounter would be coded as follows:

Primary diagnosis: 310.2 (Post-concussion Syndrome)

Secondary diagnoses: V15.59_2 (Personal History of TBI, GWOT Related, Mild (Glasgow Coma Scale 13-15), LOC < 1Hr, Post Trauma Amnesia < 24 Hr)

V70.5_6 (Post-deployment encounter)

Example 5: A family member presents to the MTF clinic complaining of persistent headaches. Complains also of blurred vision, and dizziness (unspecified vertigo) since being involved in a motor vehicle accident with loss of consciousness for 15 minutes two months prior to this encounter. Review of previous AHLTA notes reveals an ER visit with a CT scan positive for frontal contusion and coded with 851.02 and V15.59_7. The encounter would be coded as follows:

Primary diagnosis: 784.0 (Headache)

Secondary diagnoses: V15.59_7 (Personal History of TBI, Not GWOT Related, Mild (Glasgow Coma Scale 13-15), LOC < 1 Hr, Post Trauma Amnesia < 24 Hr)

907.0 (Late Effect of Intracranial Injury)

368.8 (Blurred Vision)

780.4 (Dizziness)

Most Common TBI Codes IAW this guidance		
Acute codes	V codes	Symptom codes
850.00	V15.59_2, GWOT, Mild	300, Anxiety /irritability
850.11	V15.59_7, Not GWOT, Mild	308.9, Acute Stress Reaction, Unspecified
	V70.59_5, During deployment	311, Depression
	V70.59_6, Post-deployment	368.13, Photophobia
		368.8, Blurred vision NOS
		388.3, Tinnitus
		388.42, Hyperacusis
		389.9, Hearing loss, unspecified
		438.85, Vertigo
		780.4, Dizziness, lightheadedness
		780.5, Sleep disturbance
		780.52, Insomnia
		780.7, Malaise And Fatigue
		780.93, Memory loss NOS
		784.0, Headache
		787.02, Nausea
		799.2, Nervousness/Irritable

Complete List of TBI V-Codes	
V15.59_1	Personal history of TBI, Global War On Terrorism (GWOT) Related, Unknown level of severity
V15.59_2	Personal history of TBI, GWOT Related, Mild (Glasgow Coma Scale 13-15),LOC<1hr, Post Trauma Amnesia <24 hrs
V15.59_3	Personal history of TBI ,GWOT Related, Moderate (Glasgow Coma Scale 9-12),LOC 1-24 hrs Post Trauma Amnesia 1-6 days
V15.59_4	Personal history of TBI, GWOT Related, Severe (Glasgow Coma Scale 3-8),LOC >24 hrs, Post Trauma Amnesia >6 days
V15.59_5	Personal history of TBI, GWOT Related, Penetrating Intracranial Wound
V15.59_6	Personal history of TBI, Not GWOT Related, Unknown level of severity
V15.59_7	Personal history of TBI, Not GWOT Related, Mild (Glasgow Coma Scale 13-15),LOC<1 hr Post Trauma Amnesia <24 hrs
V15.59_8	Personal history of TBI, Not GWOT Related, Moderate (Glasgow Coma Scale 9-12),LOC 1-24 hrs Post Trauma Amnesia 1-6 days
V15.59_9	Personal history of TBI, Not GWOT Related, Severe (Glasgow Coma Scale 3-8),LOC >24 hrs, Post Trauma Amnesia >6 days
V15.59_A	Personal history of TBI, Not GWOT Related, Penetrating Intracranial Wound
V15.59_B	Personal history of TBI, Unknown if GWOT Related, Unknown level of severity
V15.59_C	Personal history of, Unknown if GWOT Related, Mild (Glasgow Coma Scale 13-15),LOC<1 hr, Post Trauma Amnesia <24 hrs
V15.59_D	Personal history of Unknown if GWOT Related, Moderate (Glasgow Coma Scale 9-12),LOC 1-24 hrs, Post Trauma Amnesia 1-6 days
V15.59_E	Personal history of TBI, Unknown if GWOT Related, Severe (Glasgow Coma Scale 3-8),LOC >24 hrs, Post Trauma Amnesia >6 days
V15.59_F	Personal history of TBI, Unknown if GWOT Related, Penetrating Intracranial Wound

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E&M and procedure Coding for TBI care

Typically, AHLTA automatically assigns an E&M code for encounters based on documentation. However, these automatically generated E&M codes often do not fully account for the time and effort involved in TBI care. The following coding schema will assist providers in receiving appropriate RVUs for TBI care.

Primary Care

Initial TBI Evaluation. The automatically generated E&M should be 99203 or 99204 depending on the patient complexity and the documentation. If one of these codes is not automatically generated, you can change it manually. In addition, use the CPT code 96116- Psychomotor Neurobehavioral Status Exam, as the neurobehavioral assessment is a critical and distinctly separate component of TBI evaluation.

Starting sometime in FY09 the DoD will replace the current Standard Ambulatory Data Record (SADR) dataset with the Comprehensive Ambulatory/Professional Encounter Record (CAPER) dataset. When this change occurs you will need to start adding modifier 25 to the E&M code when you use E&M and CPT code on the same visit to avoid coding errors and loss of RVUs.

Be aware that the 96116 code is listed in AHLTA with 2 different descriptions: 1) Cognitive Mini-Mental Status Exam and 2) Psychomotor Neurobehavioral Status Exam. Select the second one.

Follow up appointments. You can usually rely on the automatically generated E&M codes. The typical E&M code for a follow up visit will be 99213. Depending on the complexity of the patient and the completeness of documentation, you may get an automatically generated 99214. If you also repeat the Neurobehavioral Status Exam as a separate and distinct component of the re-evaluation, you may also code 96116.

You are discouraged from using the CPT code 96151 because this code cannot be used with an E&M code and would then typically reduce your RVUs.