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NOTE: This updated Fact Sheet reflects use of codes effective 10/1/2010, ALL PREVIOUS VERSIONS OF THIS FACT SHEET ARE RESCINDED.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

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

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)

Diagnoses of TBI

NO

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

YES

Initial Or Subsequent Visit

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)

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 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