



Department of Defense Coding Guidance for Traumatic Brain Injury Fact Sheet February 2010, Version 2.0

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_X 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
V70.5_6: Post-deployment encounter