# Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Webinar Series

## November 12, 2015, 1-2:30 p.m. (ET)

## "ICD-10 Coding Guidance for Traumatic Brain Injury within the Military Health System"

Good day, and thank you for joining us today for the DCoE Traumatic Brain Injury November webinar ICD-10 Clinical Modification (inaudible) Guidance for Traumatic Brain Injury Within the Military Health System. My name is Sherray Holland, and I am the TBI Clinical Educator for the Defense and Veterans Brain Injury Center. I will be your moderator for today's webinar.

Before we begin, let's review some webinar details. If you experience technical difficulties, please visit DCoE.mil/webinars to access troubleshooting tips. Please feel free to identify yourself to other attendees via the Chat box, but refrain from marketing your organization or products. Today's presentation's references and resources are available from the Files pod and will be archived in the Webinar section of the DSBIC website. All who wish to obtain continuing education credit or a certificate of attendance and who will meet eligibility requirements must complete the online CE Evaluation. After the webinar, please visit DCoE.eds.tesgce.com to complete the online CE evaluation and download or print your CE certificate or certificate of attendance. The evaluation will be open through Thursday, November 26, 2015.

Throughout the webinar you are welcome to submit technical or content-related questions via the Q&A pod located on the screen. All questions will be anonymous. Please do not submit technical or content-related questions via the Chat pod.

I will now move on to today's webinar, ICD-10 Clinical Modification (inaudible) Guidance for Traumatic Brain Injury Within the Military Health System. All programs covered by Health Insurance Portability and Accountability Act were mandated to transition to ICD-10 code sets as of October 1, 2015. This transition accommodates dramatic changes in the practice of medicine and provides susceptibility to adapt as medicine changes. The new code set also provides a significant increase in the specificity of reporting allowing more information to be conveyed in a (inaudible). This webinar will address how the ICD-10 CM codes use seven alphanumeric characters to represent illnesses and conditions and present the commonly-used codes for traumatic brain injury or TBI.

Accurate ICD coding is critical. Proper coding provides a detailed clinical picture of a patient population, contributes to the quality outcomes and standards of care, permits reimbursement for clinical services, and prevents over and under-billing for services. In addition, it permits oversight of population health within the military treatment facility, a region, or the entire military health system as well as it helps anticipate demands for future TBI services.

At the conclusion of this webinar, MHS providers and coders will be able to first, state the importance of proper coding, identify appropriate ICD-10 CM codes used for TBI care, formulate ICD-10 CM codes correctly for TBI care, and lastly, apply consistent ICD-10 CM codes among providers and facilities.

I'm now going to introduce the speakers. Ms. Aurelio is a Medical Health Administrator Specialist and an American Health Information Management Association approved ICD-10 CM ECS Trainer and Patient Administration Systems and Biostatistics Activity (PASBA) in Fort Sam Houston. She authors coding clarifications and information papers on coding questions and issues, analyzes, researches, and identifies

issues and trends, and recommends solutions for medical coding questions and issues. She monitors coding regulatory changes of MHS, U.S. Army Medical Command, Centers for Medicare and Medicaid Services, and the Joint Commission. She has 30 years of experience in the field of Health Information Management training, medical coding and billing, auditing, accounting and bookkeeping, personnel, and administration.

The next speaker is Gina Lambdin. Ms. Lambdin is a PASBA coding and training department trainer, ICD-10 CM CTS approved trainer, and Behavioral Health Coding Specialist at Fort Sam Houston. She assists in writing coding manuals for various medical specialties, creates coding clarifications, presentations for documentation and coding, and revisions to the MHS Coding and Documentation Guidelines. She's served as a medical records auditor, mediator and appellate for all Army military treatment facilities. She has 13 years of coding experience with Army. Previously active duty Army before becoming a civilian Department of Defense employee with third-party collection billing for the (inaudible) and (inaudible) Region Medical Center.

The third speaker is Dr. Lynn Lowe. Dr. Lowe is an ORISE, which is Oak Ridge Institute for Science and Education, fellow, and specializes in knowledge and preservation and the rehabilitation and reintegration division, healthcare delivery, and services an Army Office of the Surgeon General. She supports the Army TBI Program staff by providing historical perspective, advice and recommendations and by reviewing program documentation and reports. She retired from the Army in 2010 as a lieutenant colonel. During her military career she evaluated and treated a full spectrum of patients referred to physical therapy with the emphasis on patients with neurological disorders. In 2007, she was appointed Rehabilitation Specialist to the Army Surgeon General's TBI Task Force. Her recognition and awards include six Army Achievement Medals, three Army Commendation Medals, four Army Meritorious Service Medals, and a Legion of Merit and the Order of Military Medical Merit.

The fourth speaker is Sergeant First Class Makowski. He is a noncommissioned officer in the charge of physical performance service line in the Rehabilitation and Reintegration Division, Healthcare Delivery and Services in the Army Office of the Surgeon General. His military education includes Airborne Trauma course, Warrior Leaders course, Physical Therapy Technician, Emergency Medical Technician course, Basic Healthcare Administrator course, Advanced Leader course, and Senior Leader course. He has several awards and decorations including – and as you can see there's a bunch on there – Meritorious Service medals, Army Commendation medals, and badges such as Combat Medical badge, Expert Field Medical badge.

Thank you all, and I'll turn it over to Dr. Lowe. Or Sergeant First Class Makowski.

Morning, everybody. This is Sergeant First Class Makowski. Today I'm going to be covering the overview of ICD-10 coding.

Our first slide here, Disclosures. Views and opinions expressed in this presentation are those of the presenter and do not represent official policy of the DOD, U.S. Army or DSBIC. Presenters do not intend to discuss off label or investigative or unapproved use of commercial products or devices. And the presenters have no relative relationships to disclose.

All right. So what we're going to start off with is a polling question, so (inaudible) activate this, and if you could just click on what type of provider you are.

Excuse me. This is the operator. I just wanted to verify the line did not drop.

Yes, right. It's still - . Okay. And looks like everybody's kind of finished up with the polling question. As you see, we kind of have a mixed version of healthcare disciplines on this call. Back to the presentation. Okay.

So ICD-10 coding overview. It is a alphanumeric representation of written diagnosis that the provider has for patients. It's established by national guidelines, and it facilitates effective, efficient data gathering, both used for receiving reimbursements for services from insurance providers and it's useful for overseeing population health, anticipated demand, assessing quality standards and managing business activities.

All right. So the ICD-10 coding, there's two ways to look up codes in the manual for them. So there's an alphabetic index and a tabular index. The alphabetic index is just like it sounds. It's an alphabetic list of terms with their corresponding codes. And, as you see in our example here, you can search for something such as pain, and it breaks it down into joint pain. And then it breaks it down even further into ankle, elbow, foot. If you see the little dash right after the code, that means there are following codes, or more codes to add onto that. And we'll touch on that a little bit later.

The second part to it is the tabular index, so it's a structured list of codes divided into chapters based on the body systems or conditions. So it's essentially broken down into chapters of injuries, musculoskeletal, illnesses, diseases, things of that sort. And if you look at the example that we have right under that, the SO64 Concussion, so search for concussion, and then it breaks it down even further into the further detail of coding underneath that category.

Key changes between ICD-9 CM and ICD-10 CM, ICD-9 was only three to five digits whereas ICD-10 is three to seven digits. ICD-9 was approximately 13,000 codes. It had limited capacity for adding new codes, and the structure was always the first digit is alpha or numeric with digits two through five being numeric. The issue that we started running into with the ICD-9 CM is it had a lack of detail. So as the medical services expanded, then there was not proper coding to gather the proper information or the proper detail on those diagnoses.

Now ICD-10, on the other hand, has approximately 70,000 codes. It has a very flexible capacity for adding new codes. And the structure of it, the first digit is always going to be an alphabet, and then digits two through three are going to be numeric, and digits four through seven will be either alpha or numeric. It is extremely detailed so you have the laterality – or left versus right, your initial versus subsequent encounter, routine versus (inaudible). It breaks it down into a much more detailed level. If you look at the example below, ICD-9 for hearing loss was just 389.9 for the code, whereas in ICD-10, you get unspecified ear hearing loss, right ear, left ear, or bilateral. So that breaks it down in to a much more detailed thing, so that helps pull data. It also helps to diagnose and document properly in that patient's records.

So the format and structure, we're going to go over the tabular lists. So for the tabular lists, there's categories, subcategories and codes. The characters for categories, subcategories and codes may either be a letter or a number. So the categories are three letter characters – a three letter character that has no further subdivision is also equivalent to the code. So as we go into that a little bit later, I'll give you some examples.

Subcategories are either four or five characters. So a code may be anywhere between three and seven characters. Each level of subdivision after a category is always a subcategory. The final level of subdivision is the code, so if there's no other subdivisions underneath that, then that is considered the actual diagnosis code.

Some codes have an applicable seventh character, and those are still referred to as a code, not a subcategory. If a code has the applicable seventh character – if it is supposed to have an applicable seventh character, it's considered invalid without that seventh character added onto it. So the example below of the category would be M20, acquired deformities of the fingers and toes. Now that category breaks down as the different subcategories, so you add your fourth, fifth, sixth, and potentially seventh character depending on the code to add the specificity into that code. So if you go to M20.022 is a boutonnière deformity of the left fingers. And that is the highest character of subdivision which is considered a code.

In the example here, this is a screenshot from the training application for AHLTA, you may search by common terms, such as ankle sprain. You can also search by your codes if you know the category codes. And just look how in AHLTA right now with ICD-9 CM it breaks it down into the diagnosis tree, so if you hit the little plus arrow beside it, then it will break it down into further subdivision. The bold diagnoses are going to be the ones that you can add to the encounter. So as you see, the short Achilles tendon diagnosis of M67.0 is broken down into subcategories that are actual codes, because they are bolded, and that has the specific codes for the unspecified right and left or anything like that. And it will be like that for all diagnoses, not just necessarily musculoskeletal.

So getting a little bit more into the ICD-10 codes, the codes A00.0 through T88.9 and Z00 through Z99.8 are used to identify diagnosis symptoms, conditions, problems, complaints, or other reasons that a patient came in for an encounter. Codes R00 through R99 are signs and symptoms codes. So the signs and symptoms codes are used whenever there's not a definitive diagnosis that has been established for that patient. So if you're looking at swelling, bruising, or something similar to that, but no definitive diagnosis has been associated with it.

So you would not use a sign and symptom code if it's considered part of a disease process. So if you have a broken bone, of course, you know, you're going to have swelling, you're going to have bruising. You would not use that signs and symptoms code. But if the signs and symptoms are not part of a routine diagnosis, then you should code it on with it.

Codes V00 through Y99 are external (inaudible) codes. They have the place and activity codes used on the patient's first visit. The place and activity is only used on the first visit. You would not continue to use that through routine encounters or follow-up visits or anything like that. These codes also contain environmental circumstances that cause injuries or other adverse effects. Where applicable you would use with the diagnosis code to help classify the condition. And use to provide additional information as to the cause of the condition.

Okay. The seventh characters. Not all of the ICD codes have seventh characters. But if they do require seventh character, you will be required to use that in order to make it an official code. So the seventh characters, there's a group load of them and we'll go over each one of them individually.

The seventh character of Alpha is considered the initial encounter. So it's whenever they are receiving active treatment for that specific diagnosis. Now active treatment being based off of the patient's perspective. So if they come into an ER with a broken bone, they would get that seventh character of alpha. They get sent to Ortho on that same day, it's still that active treatment for that same day, it would be alpha. But if they come back for care later on regarding that same injury, then it would be considered a subsequent encounter, which is our next seventh character of Delta.

So these are subsequent encounters used for routine care during healing or recovery phase. Some examples of that being cast change or removal, an x-ray, checking up on healing status, medication adjustments or after care or follow-up visits or treatments for those injuries and (inaudible) conditions.

The seventh characters on this slide are mainly referred to during fractures, so seventh character of Bravo would be the initial encounter for an open fracture. If it was a closed fracture, then it would still be considered the Alpha seventh character, but open fractures are Bravo.

The Gulf is a subsequent encounter for a fracture with delayed hearing.

Evo is subsequent encounter for a fracture with non-union. And Papa is the subsequent encounter for a fracture for non-union.

All right. The seventh character of Sierra, is a sequela. Now the sequela is for complications that arise as a result of a condition. So this is used for both the injury code that caused the sequela and the sequela itself. The Sierra seventh character is only added to the injury code. The S seventh character identifies

the injury that is responsible for that sequela. There's no time limit on which the sequela codes can be used, and the type of sequela is always sequenced first followed by the injury code. So I have an example of a scar. So if a patient came in with a burn, they would be coded for that burn. And if that burn led to scarring, then that is the sequela of the burn. So you would code the scar first, and then you would code the injury, or the burn, with that seventh character of S.

Another example is your M24.561, contracture of the right knee. As you see in my little box there, this is considered the sequela because it was caused by an actual injury, which would be the D22.321, which is a spontaneous disruption of the ACL ligament. Now as you see, the S is added as the seventh character to the actual injury in this example, saying that the ACL disruption was what caused the contracture.

The big thing with this is that you can only code what is documented. So if you don't document the cause, then you can't code for it. So you might have to get a little bit more into your actual note itself and explain that the ACL disruption caused the contracture.

The next thing we're going to discuss is placeholder characters. So the placeholder character of an X allows for codes to have future expansion. So where there's an X, that will be used in the middle of a code for the possibility for expansion. If a code requires a seventh character and is less than six characters long, you would use a placeholder X to fill in the empty characters. So some examples down here at the bottom. Examples to allow for future expansion. The M53.2X6A, which is spinal instabilities of the lumbar region initial encounter. That X in the middle of that code can allow for a future expansion to say maybe it's a medial-lateral, anterior-posterior, however they determine that they want to pull the data for that. It is a code that requires a seventh character, as seen in the S33.6XXD, sprain of the sacroiliac joint subsequent encounter. The sprain of the sacroiliac joint is the S33.6, but the guidelines say that it needs a seventh character, so just to make it that seventh character, you've got two Xs in there in order to make that D that seventh character.

The same thing with the example right below it with injury of the radial nerve, upper arm level, right arm. So they have that X in there just to make that Alpha the seventh character.

All right. The medical record, whether it be paper or electronic, is a legal record of care, so you've got to make sure that all coding must be supported by the documentation in the medical record, whether you use templates or type it out as a free test. Make sure that everything is supported. When there's a difference between what is coded and what is documented in the medical record, that coder – there's a possibility to change the code to more accurately reflect what's in the documentation. So if you're not capturing everything that's required for that code, that coder can actually pull some of your coding off or modify it in order to make it reflect what is in your documentation. When this occurs, the coder should notify the provider. And if that does not happen, that's where you've got to monitor your resource management and your statistic (inaudible) to ensure that your coding is accurately reflecting what you're doing. The provider is ultimately responsible for coding and documentation, so you want to make sure that you are capturing it as much as possible in there in order to capture your proper productivity.

This one here is the Healthnet.mil. This site here can be used in order to look up some of the coding guidelines and also keep up to date with any other changes in the coding.

Next presenter is going to be Lynn Lowe. I'm going to turn that over to her.

All right. Can everybody hear me? And to my chagrin, see me? But here we are. I'm going to cover some of the specific coding (inaudible) related to traumatic brain injury. Thank you to Sergeant Makowski for giving us the overview of many things related to TBI and using many TBI examples, but I'm going to go through the codes that are most pertinent to those of you who are treating and then coding for TBI-related care.

So I have to start with the disclosures as well. Each of us gets to do this. I have no relationships to disclose, and I'm not going to discuss any off label or unapproved use of commercial products or devices. And these views and opinions are those of the presenter, myself.

So what's on your screen now is a pre-release version, preview I should say, of the diagnostic coding guidance tool that has been developed collaboratively with DVBIC and with many coding experts giving input and advice. It's set to be released very soon, and the idea here was to try to synthesize about, oh, 160-some pages of the MHS Coding Guidance that were the pieces that were related to TBI to a usable tool that would be provider friendly and that would highlight for you the things that are most important. So this is the DVBIC version. This includes all levels of TBI, and you can see in the top left there, although you can't see it real well because we're still working on finalizing it, but a little schematic to tell you if this, then we code it this way, if no, code it this way, if it's initial visit, you code it this way. So some of those very fine details are still being worked out, and we'll get that out to you. But this tool will be coming to you soon.

On the next slide is another version of this. The Army published what they called a cheat sheet for concussion coding. Not all levels of TBI but really specific to concussion. This is actually a three-page document. You just have a screenshot of it here. Again trying to give providers a handy tool so that coding would be a little bit easier for them. We had these for ICD-9. They were available for download. And were quite popular. Our providers often would make comments on them and we'd have to tweak them from time to time, but if you went into a provider's office, you often saw that cheat sheet so we knew it was probably being used. And that's why we've been working on creating the equivalent for ICD-10.

Actually I'm curious – we're going to have another polling question here – if anyone has seen or used coding tools, cheat sheets, in their practice. So they'll put out the poll here, and we'll see how many of you are taking advantage of these tools.

Uh oh. The more people that respond, the less yeses we're getting. But it looks like about 50/50. We can end that, and definitely want to end it before we get too many more no's. No, I'm just kidding. We hope that you will use these kind of tools. We don't expect everyone to page through the whole MHS coding document, although I do want to say that that is the ultimate resource and the ultimate source. If you do have a coding question, you should work with your coders, and they're going to use that coding guidance, not our little cheat sheets, as their official guidance.

Looks like we jumped to the beginning of the webinar. I'm going to get back to where we were. And we're going to talk about the first code, the screening code. Most care for concussion, especially, starts with screening. How do we know someone had a concussion? You have to ask them the questions. Did they have an injury event? And did they have an alteration of consciousness at the time of that event? So the screening questions are the first two questions in the MACE. And if you, in your visit, if a patient presents to you for care, and you think you need to screen them for concussion, the MACE would be the appropriate tool to use. And if you do use that tool, and their screening comes out negative, that it wasn't a concussion because they didn't have any injury event, or it wasn't a concussion because they had an injury but they didn't have any alteration of consciousness, no loss of consciousness, no post traumatic amnesia, then you would code that as a negative screening.

If you do the screening and it comes out that it was positive, then the screening code's a DOD specific code. These were created specific to DOD, so if you're working in civilian practice, these codes are not available for you. But in a DOD practice, then you would screen this as a positive TBI. There are a couple other codes listed up there for completeness, that if a patient declined to be screened, or you couldn't do the screening, then there would be an appropriate code to be used.

The important thing about screening codes is if the reason for your visit was the screening, then your result of the screening should be the first code you put in the order of codes at the end of your note. And when you decide to code your note. The reason for the visit, in all cases of coding, is your first code. That's your primary code. So if the reason for the visit was to screen for concussion, screen for TBI, this is the right code to use first.

If, however, the reason for the visit was because someone came in with some symptoms, they came in with a headache, they came in with some dizziness, and during the course of your examination you decide you should probably screen for concussion, and you're investigating the problem, then we don't use – and if as you're investigating the problem you find out it's not a concussion, then it would be appropriate in your coding to still code that it's a negative screening even if the concussion – if the reason for the visit wasn't screening. Maybe it turned out that it was just a laceration on their head, and you screened them. So you code the laceration, that's what they have, but for very good care, you also screened them for concussion and you found out that was negative. And using that negative concussion screening would be the right thing to do.

Unfortunately, the way the coding rules are written, if a patient comes in with those symptoms of a headache and some dizziness, and you screen them for a concussion and the concussion is found, that yes, they have a concussion, because the reason for the visit wasn't screening, the reason was a clinical sign or symptom, then the screening code is not used. The current guidance says that with a positive diagnosis, if the reason for the visit wasn't screening, that in the presence of a positive diagnosis we do not use the TBI screening code.

So one other point I want to say about the screening codes is one of the bullets on your slide, but this is usually only used once per injury event. We don't continue to screen someone even if in your clinical practice you have a patient that you feel is appropriate to repeat the MACE on a subsequent visit, if you already know they have the diagnosis and you're repeating it because you want to see if they have shown some improvement, that may be appropriate in your practice but it wouldn't be appropriate to code for screening more than once for that injury because you already know the diagnosis.

So that's what I'm going to give you on screening. Let's move on to diagnostic codes.

There are two different sets of rules for inpatients versus outpatients for diagnostic codes. In the inpatient setting you are allowed to code for rule out or possible or likely diagnoses. In the outpatient setting, you are not. So you need to make sure you're following that guidance. If in the outpatient setting you think they might have a concussion but you can't diagnose it, you need to code to the highest level of certainty that you have for that visit. Code their signs and symptoms, code an abnormal test result, code any other appropriate code for that visit. But if it's not a confirmed diagnosis, in the outpatient setting you don't use TBI diagnosis codes.

All right. A little more on diagnostic codes. They typically are in the first or second position. We just talked about screening codes and how if the reason for the visit is screening, then that code would be sequenced first. If the screening was positive and the reason for the visit was screening, then the second code would be the diagnosis code.

A big change between ICD-9 and ICD-10 is that the diagnosis code is used not only on the initial visit, but it is used on all visits throughout the episode of care. This certainly helps our surveillance efforts and in some ways will simplify some of your other coding. So the codes, the seventh digits that Sergeant Makowski talked about, A for initial visit, D for a subsequent visit, and S for a sequela visit, will help tell us where the person is in the point of care and throughout that episode of care, but that diagnosis code will be carried throughout the entire course.

So I have here for you a list of the most common TBI diagnostic codes. These would be for the full range of TBI, so fractures of the skull. Concussion is the S06.0 and then there's some placeholder Xs there. We'll talk about the greater detail of that in a moment. But that category, S06, is most of our brain injuries. And fracture of the skull, the SM2, certainly can result in some brain injuries as well. It's about the same size list as ICD-9, but once you use all the placeholders and X's, it really expands the specificity of our TBI coding compared to ICD-9.

This chart shows you just the ICD-10 concussion-type codes, so it breaks out that S06 category into a lot more detail. So you may have the concussion with no loss of consciousness, and the first three there are grouped that that's the initial, the subsequent or the sequela visit. You could have the S06OX1 as an

initial, a subsequent or a sequela. That's the one that had loss of consciousness less than 30 minutes. And there's actually – instead of that "1" in the sixth digit, there's 2, 3, 4, 5, 6, 7, 8 for different periods of time, so that can give us lots of detail. And if we don't know the duration or it's unspecified in the documentation, then you would use the S06OX9 code.

Those are a couple short lists on the diagnosis coding.

All right. We're going to move on to symptom codes. So symptom codes, as you heard Sergeant Makowski mention, are usually the R codes, R00 to R99. The TBI is not a diagnosis that has a very universal presentation, so let's compare it to ankle sprain. If you sprain your ankle, you pretty much always have pain and swelling. So in our coding rules, if you sprain your ankle and we code for ankle sprain, then you don't have to code for pain and swelling because it's pretty much understood that you will have pain and swelling with that ankle sprain.

We don't have that for a concussion. Certainly there are some common symptoms that folks have, but there isn't anything that's universal. So it's important in TBI coding and concussion coding that we do list using our ICD-10 codes, the sign or symptom codes that are appropriate for the patient that we're seeing. And we'll talk about the exact sequence. The most significant symptom, whatever that might be, maybe it's their double vision. Maybe it's dizziness. Whatever it happens to be. And they may have more than one. They may have six or seven. Typically we find two or three. But the most significant symptom is coded earlier in the list, and any further symptoms are coded at the end of your list of codes.

The real surveillance impact of using the symptom codes with the diagnosis is getting a good picture from the surveillance perspective of the number and duration of symptoms related to TBI. So if you code, as we're supposed to now, with the diagnostic code throughout the course of care, and that diagnostic code was either a D or an S seventh character, it codes on the same visit as symptoms, then we can get a picture of how many folks with a concussion are having persistent headaches. How many folks with concussion are having persistent dizziness. How many are having persistent emotional disturbance. Any of those pieces can help us be better prepared with the right number of staff, and the right skill sets of personnel to manage and care for those patients. So we definitely are not following that more general guidance of not coding signs and symptoms just because we use a diagnosis code. We are encouraging you to include all the signs and symptoms that are appropriate for your patient.

We've listed here some of the most common signs and symptom codes. The tool sheets that I presented initially have lists of these. We want to make the point that it is important that you code to the highest level of specificity on your symptoms. So if they have hearing loss, for example, is it both ears that they're experiencing hearing loss in, or is it just their right or just their left. To keep these symptom lists from being six pages long, we use bilateral as kind of a default. But if that isn't true, if it really is just the right or left, then there's a code, a zero or a one, that would be for right or left. I'm sorry. A one or a two for right or left. Zero would be unspecified. Uh, I might have that wrong. It might be nine is unspecified. Let's see. Yeah, if it's not specified it's zero. Right or left is usually one and two. And bilateral three.

So certainly this is not the exhaustive list of any symptom that your patients could have. Hopefully you don't have patients that have all of these. That makes your coding list very long. But this would be a good starting point.

So let's take a break here and see if we just going over screening, diagnosis and symptom codes, let's look at this scenario. If a soldier presented to a clinic and complained of headache after a motor vehicle crash two weeks ago, and we looked through their medical record and you found that they were coded with a SO6 concussion code, you know that SO6 should start to get familiar to you like 850 used to be. And the 0X1 telling us that this was a concussion with less than 30 – let's see, 0X1. Yes, less than 30 minutes of loss of consciousness. If that's how they came in today, what would your primary code be?

Give you another little bit to answer here. All right. So more than half of you got that right that the code on the follow-up visit would be the symptom. That's why they're there today, because of their headache. We would then code the D code. What would your choice be there? We would code that next, so we're

carrying the diagnostic code all the way through. We wouldn't count this as post concussion syndrome at this point, it's just a headache, and it's only been a couple of weeks. And we wouldn't call it a sequela because it's not uncommon in the typical course of healing that you would still have a headache two weeks after a concussion is not uncommon. We aren't going to call that a persistent symptom yet, so we wouldn't get to the point of calling it a sequela visit.

So good job.

So let's make it a little more complicated. We'll add on a few more codes now.

So deployment status codes. In ICD-9 we had our V70 codes. This is the somewhat equivalent replacement for that. There's just two choices. We have currently deployed or history of deployment. So when we see the Z5682, currently deployed, code on a record, we're going to assume that that injury occurred in theater. And that visit is in theater usually. Without that code we have to determine about how – have to use some scenarios and look at deployment histories to try to figure out if people were deployed or not. So if it's a currently deployed situation, please use the Z56. If this is resultant from a history of deployment, then we'll use the V91.

For our coding to really pick up these kinds of codes, they have to be in position two, three or four. And we'll show you the sequence in a little bit, and it usually sits there. That's part of the reason we split up the symptoms, and we put just the most important symptom, or most significant symptom early in the list of codes and the other symptoms at the end because we want to make sure that if there is a deployment status code that there's room for it in the top four.

All right. So that's a pretty easy one. You should know if they're currently deployed or not.

This one gets to have a little more detail. The external cause of morbidity codes. These were the equivalent to the E codes in ICD-10. There is a much stronger push under ICD-10 to include the external cause of morbidity codes to really provide more data for research for evaluating injury prevention and for surveillance purposes that we – all providers and all coders work to put an external cause of injury code on our encounters.

This tries to capture – and you can use more than one of these because we may be capturing how the injury happened, where it happened, the patient's status when it happened. There's multiple codes that may get used. There's kind of two groupings of these codes. Some of them are more simple three or four-digit codes. Codes that don't have a seventh digit. Those may be used only once. Typically those are the place of injury, the place of the occurrence, or the status of the member, the patient. And then there's codes like the ones on this slide that have a very detailed description. Car/driver. Injured in collision with a sport utility vehicle in a traffic accident. That's a very detailed code. That's why there's so many of these V codes, because there's another one very much like this that says you're the passenger injured in a collision with a sport utility vehicle in an accident. Or maybe it will say that you are in a sport utility vehicle – or not a sport utility vehicle, but you're in a military vehicle. So there's a long list of detailed injury codes.

They're searchable. If you need help when you're coding, there's searchable lists and there's lists that try to break this out for you by driver versus passenger, things like that.

The one E code that people were probably the best at using under ICD-10 was our blast-related code. So the equivalent to that we put in the slides here, the Y37230. And we would use this throughout the course of care, so if someone was injured by an IED blast, it's a military personnel, this code would follow them throughout their course of care.

The next slide gets a little more detailed about these place of occurrence and activity codes. Like I said, they're a little simpler, these Y92 or Y93 codes. Here's the level of detail you might run into with a patient that fell in their bathroom and hit their head. So you could use that place of occurrence, bathroom, unspecified, institutional or private residence as the place of occurrence for their fall. So you would be

using a V code for their fall, and then you would use this Y92 code so we knew that they fell in their bathroom. I'm sure we've all seen statistics and heard things reported through research findings that say bathrooms are a common place of falls. Now we can get to that in our coded data of our records, not by searching through the text of records if folks will use these place of occurrence type of codes. Maybe they fell in their garden. Maybe they fell in their driveway. All of those are options under these place of occurrence codes.

Maybe they fell when they were running. Or maybe they fell and hit their head diving. So that would be an example of an activity code of what they were doing when they injured themselves.

The idea here is to put as much detail in the codes as possible. So there are many, many codes available. Again, they're searchable. It comes down to your documentation. The ones that are the most common in your practice, you probably want to keep those handy and desk side. And if they're not so common, you'll use your search features in your coding tools to get to that level of specificity. But that's what the coding in ICD-10 is really asking us to do is to make sure we increase this level of detail.

You'll notice that the Y92 and Y93 codes are somewhat simpler. They don't have a seventh digit. These codes are used only once per injury event, so at that initial visit. Somewhat to how E codes were used in the past. But many of the injury codes have seven digits and are used throughout the course of injury like the last one I showed on the last slide. So there is, like I said, two groups of these external cause of morbidity codes.

All right. We'll move on to our DOD unique personal history codes. Personal history of TBI. You might remember them from ICD-9 as our 1552 codes. And there were 15 of them. Because we had GWOT, Not GWOT, Unknown if GWOT. And within each of those we had each severity level. Under ICD-10 we have just five. We don't differentiate GWOT versus non-GWOT because we can get those from the place of injury codes now. So in our personal history codes we just have the four. (Inaudible) unknown level of severity, mild, moderate, severe, or penetrating injury.

Our personal history codes are currently the guidance says that we are to document the personal history code at all visits, our initial visit and our subsequent visits. This is the same guidance that we had under ICD-9, and it was very important under ICD-9 that we had these personal history codes because we only had the diagnostic code on that first visit. And if you – without the diagnostic code, if someone came back for their follow-up visit, as our example was earlier, with a headache, you wouldn't know if there was – if the headache was from a TBI or not. But under ICD-10, since we use the diagnosis code all the way through, that personal history code isn't necessary for us to tell that it was from – that the headache was from the TBI. But the guidance still says we have to use it on every visit. That could change in the future. We're trying to simplify things for those of you out there, but as it is today, you do have to use your personal history codes on every visit.

There is a personal history code that is not DOD specific. It's this Z87820. So in private practice, civilian practice, you would use that as a personal history of TBI. But our TBI codes are more specific because they get to the level of the TBI, the severity level. We would prefer (audio break) the personal history codes that are DOD specific.

One more point I want to make about that. Give me a second here. I'll wait and discuss that in our examples I guess.

All right, so here's the slide – if you were going to print out maybe one slide from this slide deck that would help you the most – is this order of coding. It does matter. So we talked about screening code being first if the reason for the visit was screening. And then your diagnostic code and your symptom codes. This would be for an initial visit. If it was deployment related, that would be fourth. And then your external cause of morbidity codes. I know we just have that numbered five, but there could be a couple of injuries. Maybe there was a blast and a vehicle accident. So there's two external causes. You don't necessarily know which cause the TBI, so you may have to use two of the seven digit external injury

codes. And then one time only you would use the place of occurrence and the activity code if there is one that was applicable. And finally the personal history code.

On the subsequent visit, where it's a little bit more simple, you don't use the screening code again, and you start with the symptom code. And then the diagnostic code, the deployment code, the external cause of injury code and personal history code. And these are for if a TBI was diagnosed.

So the cheat sheets are here for you. Both pages of them are here. They're also available as a download. And hopefully that will synthesize the information, not only from MHS guidelines, but also from our presentation today, and make your job, as you're finishing up your visit with your patient and needing to code it, or if you're a coder and you're reviewing these notes, that would make that a little easier.

The last point on coding I want to bring up before we turn it over to some cases is a point about evaluation management codes. For primary care providers and non-rehab providers, the E and M code generates most of your relative value unit. For an initial evaluation under the DOD side, AHLTA will generate an E and M code. And if you have done sufficient documentation, it usually automatically generates a 99203 or 204 code, depending on the complexity of your documentation.

If it doesn't automatically get you to this level, you may need to beef up your documentation so that it does because TBI care is typically more complex than a routine primary care visit, and we want to make sure you get credit for that. If you do a neuro behavioral status exam as part of your initial visit, you can also add the CPT code 96116. Make sure that you have sufficient documentation of that in your notes. But that CPT code will generate additional RVUs. When you go to code that, there is a drop down. And there are two choices. I believe you have to always choose the second one so you get the right code.

All right. And one other piece of this is modifiers. I don't know how many of you are used to using modifiers, but if you, as a provider, put the modifier 25 on your E and M code when you're also coding a CPT code at the same visit, that allows those two codes, the E and M code and the CPT code, to be used together. Otherwise many of the coding softwares that are used to check our notes take out one or the other code, usually the CPT code, if you don't have the 25 modifier on there. There it is. It's the two descriptions of 116. Make sure you select the second one, the psycho motor neural behavioral status (inaudible).

All right. I'm going to turn it over to our official coders. They're going to go through a couple cases with us. Take it away, Judith and Gina.

Okay. Hang on a second.

Okay, let me read the disclosure first. The views and opinions expressed in this presentation are those of the presenter and do not represent official policy of the DOD, the United States Army, or DBVIC. The presenter does not intend to discuss the official labels investigative unapproved use of commercial products or devices. The presenter has no relevant relationship to disclose.

Okay. Same thing applies to me. I have no relevant relationships to disclose and do not intend to discuss the official label of commercial products or devices.

Okay, on the next few slides, we have some coding examples which are taken from Appending G of the MHS coding guidelines. On this coding example A on this slide, this is a soldier hit by IED blast who denies loss of consciousness but reports seeing stars, stumbling around for a few minutes, and cannot account for approximately 15 minutes of activity after the explosion. This is an initial encounter where a patient was evaluated. Soldier is asymptomatic and MACE score is 30 over 30.

If you look at this, this is more of like a command directed training for a soldier who is asymptomatic. If you look at the answer for coding example A, under the new DOD unique codes, we have provision for screening for traumatic brain injury with positive findings, which is DOD01222, which would be reported

on this coding example. This is one of the changes we can see in reporting screening code TBI with positive findings and assigning the DOD unique code. Additional codes will be reported to code ICD-10 S060X08, concussion without loss of consciousness. Also report Z56.82 to indicate that the patient is currently deployed. Also report Y37.2308. This would indicate the injury happened during military operations involving explosion of IED, and it is an initial encounter with a A as the seventh character. Also DOD 0102, personal (inaudible) of traumatic brain injury, highest level of severity mild, which is equivalent – this is equivalent to V1552 in ICD-9. It is also reported.

The testing of a person who threw out or (inaudible) a suspected diagnosis because the patient had some sign or symptom is a diagnostic examination and not a screening. In this case the sign or symptom is used to explain the reason for the test. The screening code may be first listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. This is as per Coding Clinic First Quarter 2005, pages 69 to 81, with effective discharges of April 1, 2005. Also as per ICD-10 CM Guidelines, Chapter C, Chapter Specific Coding Guidelines, Chapter 21.C.5. Should a condition be discovered during the screening, then the code for the condition may be assigned as an additional diagnosis.

Also please note that not every time they do the Military Acute Concussion Evaluation, which is the MACE, which is considered a screening, the DOD 0121, TBI negative, or the 0122 screening is reported. So not every time they do the MACE screening codes will be reported.

If these were a spouse of a Marine, you use V87.820 in place of unique code of DOD 0102.

On the next slide, the coding Example B. On this slide, a patient suffers from headache which dates back to an explosion occurring in Iraq two weeks ago. When the provider reviews the previous AHLTA notes, an injury event was associated with an alteration of consciousness, coded with S06.0X08. This encounter will be coded with D44.319 for headache as the primary diagnosis.

But I guess we have a polling question, number four. Which list correctly codes this encounter? Is it A or B?

Okay, the answer is A, symptoms coded before diagnosis. Also sequence encounters and external causes of morbidity codes are used throughout the episode of care.

On this one the G – these are the codes – I'm sorry, this is coding example B. G44.319, acute post-traumatic headache not (inaudible) would be the primary diagnosis. And then the subsequence which has the V, concussion without loss of consciousness, will be secondary diagnosis. Under the history of deployment, assuming that this encounter is a post-deployment follow-up visit, so we code Z91.82. And then Y37230D, military operations involving explosion of IED, would be also coded or reported. And then the DOD 0102, personal history of TBI, highest level of severity mild, (inaudible) mild, (inaudible) TBI severity is mild on this Appendix G of the MHS guideline. Note that DOD 0102 associates the acute symptom headache with TBI.

Gina?

Okay. For the last two examples, so example C. This is an example of a delayed diagnosis. So an Airman presents for an evaluation after she answered yes to one of the TBI questions on a post-deployment health assessment. The provider reviews the AHLTA note, and it states that in theater the patient had a fractured arm and facial contusions six months ago after the injury as being a passenger in a military vehicle crash, but no documentation of a TBI evaluation, no MACE, and no TBI diagnosis was coded.

The follow-up visit that she had, not this current one but follow-up visit she had, was for complaint of a headache, but no documentation of ever treating the headaches. Upon evaluation she reports that the motor vehicle crash while deployed in which she suffered a broken arm and facial contusions, the patient's interview revealed a report of persistent headaches since the accident, no previous history of

headaches, tinnitus for ten days after the accident, and intermittent dizziness and blurred vision since the accident, and self-reported feeling groggy for a few hours after the crash and poor recall of the events.

So in this particular visit the provider did do a TBI evaluation that came out positive. And the next question is a polling question. So which one of these would be coded as appropriate since the provider did do an initial TBI evaluation? A or B?

Okay. So the answer – in just a second it will pop up – is actually A. The provider will go ahead and code the evaluation as positive for the concussion. And it is an initial visit for the concussion itself. The patient still has post-traumatic headaches, so the headaches would be listed as second. It happened during a deployment, so it is considered – a post-deployment code would be used with the Z91. She was a passenger in a military vehicle, though it didn't state it was actually due to any type of military activity, she was still the passenger. And then the history of the DOD – I mean the DOD code for the history of the traumatic brain injury.

Okay. On the last example, this is an example of actually a dependent – so this is not an active duty person, it's a family member – is seen for his diabetes with manifestations of hypoglycemia and insulin management. He had a TBI from a fall two years ago, and he has occasional petit mal seizures and short-term memory loss as late effects of the TBI. Mr. Gonzales has several incidents of hypoglycemia or hyperglycemia. He is at risk for additional falls.

Okay, so the answer that we have for this one is that you would actually code the diabetes first. And if the provider would document this a little better, but look back in the records, we'll find out that the patient did have a confirmed TBI. The TBI with the S on the end for the sequela would be listed as second, with then the manifestations that came up with that for the seizures and the memory loss which are going to be treated. And then long-term use of insulin. And in this case, the DOD history code would not be used. You would actually use the Z code, the Z87.820 for a personal history of traumatic brain injury. Those will be used for dependents and civilians when they're not related to a military activity.

The last few slides are the resources that we have and where we have gotten a lot of our information, so this presentation and the resources are available online. We also have some websites attached on a couple of the last pages.

And that would conclude the presentation.

Thank you to all the speakers for your presentation.

If you have any questions for the presenters now, please submit them via the Q&A pod located on the screen.

It is now time to answer questions from the audience. If you have not already done so, you may submit questions now via the question pod located on the screen. We will respond to as many questions as time permits. So, there's a lot of questions here, of course, (inaudible) an important subject. So this one I'll just throw out here. Using the seventh character A for initial evaluation is pretty straightforward. But are follow-up encounters C, subsequent, or S, sequela?

This is Dr. Lowe. I can take that one. And the answer is it depends. So if it's in the normal recovery and healing phase. And this would be a typical presentation if someone is recovering from a TBI, then it would still be in a subsequent, thus the D code. If the patient's presentation is getting to a more chronic phase, and they're having these persistent symptoms that we really believe are sequela of the TBI, and aren't from something else or another diagnosis, then at some point in time, which is not defined, the clinician will decide that this really is more of a sequela, it's persistent, it's not just part of healing and I'm not expecting it to go away necessarily, so that would be coded, then, as a sequela S. I know that's not very specific guidance, but that's the most detail I can give you I'm afraid. It's a clinical decision for when it changes from a D, kind of a typical healing, to a sequela. Over.

Thank you, Dr. Lowe. Another question regarding screening. Can a screen be completed ten years after the event? And this is the first or initial visit for the service member that never reported issues previously but currently they're being seen for reporting longstanding untreated symptoms.

And I can repeat that question. It seems to be a long question. Do you need me to repeat it?

No. I mean a patient can be screened for a TBI at any time if they had never actually stated that they were ever in an accident, but the current symptoms seem to be from those events, they can still perform the screening if it is a soldier. We definitely want to see that they have performed the screening.

Great. Thank you, ma'am.

The next question is, do we still need to code for GWOT, non-GWOT? If so, how?

So in the beginning – towards the beginning of the presentation, Dr. Lowe had actually explained that we now have the DOD history codes, do not have to express the GWOT because we have specific ICD-10 codes that actually apply to whether the patient was deployed or not. So they would be teamed up with those DOD codes.

Great. Thank you, ma'am.

The next question is, do you use the DOD or the D code for a veteran you are seeing in the community who received his TBI while on active duty?

Can you repeat that question?

Sure. Do you use the DOD or the D code for a veteran you are seeing in the community who received his TBI while on active duty? I guess regarding the screening.

Well, I have to defer to Judith and Gina. Are the DOD-specific codes even available in the private care setting for them to use?

No.

Are we not – I misunderstood the question, then. I thought it meant that if it's like a retiree who had a diagnosis and is continuing to be treated do you use the DOD codes? If yes, you can for retirees as active duty. They're not used, though, for dependents or civilians who are seen in the military facility.

Okay. Thank you. I guess whoever asked that question, if you want a more specific answer, you can just email us back, or put another question in.

This question states, if the personal history of TBI code is eighth on the list, I believe it would not be counted as our system can only query the first four codes. How, then, will be pull data on severity of TBI looking back?

This is Dr. Lowe. That can be a problem in the outpatient setting where only the top four codes are pulled into our general coding M2 database. There's work to increase the number of codes that are pulled so that – but those codes are still attached to that record, and so some detailed analysis can be done going to the initial records, not to the dataset that's extracted from the AHLTA system. And so it still can be valuable. Again, we're not – under ICD-9 we were very, very concerned about the personal history codes because that was our only way to link them to the symptoms that were persisting and to know that those symptoms might be related to a concussion – or a past concussion. That's not the case with ICD-10 because you're carrying that diagnosis code all the way through. So that's why we have it at the bottom of the list. Over.

Thank you. This question (inaudible) read and understand. It's the interpretation of episode of care, different cross providers. Then assignment of A or D will vary and hence not be useful for surveillance. For example, they give two providers see a patient on day one. Both provide the S06.1X0A. However, if the patient is told to come back the next day, is that an A or a D code?

So that's both an easy and a hard question. The next day it would be a D code. On the same day there is a provision to use the A code, the initial encounter code twice, so maybe they see someone in the ER and then go straight to a specially trained TBI provider in primary care. And both that ER provider and the provider in primary care could use the A code on that day. So our surveillance efforts are going to account for that possible twice in one day occurrence. You know, in an ideal world it would only be used once per injury event, and every time you had an A with one of our SO6 codes you'd know that was a new concussion. But because the coding rules allow it to be used twice in one day, if two providers truly are doing that initial evaluation and initiating the care, then we have to have our surveillance efforts account for that. But anything beyond that initial day, when we're following the course of recovery, maybe adding some additional treatment, they're getting active treatments and following that recovery and healing, we're going to code those as subsequent or D encounters. Over.

Thank you, Dr. Lowe. I think we have time for maybe one or two more questions, so this question states, how will the DOD track numbers of TBI encounters if the personal history of TBI codes is in different locations in the order of coding?

As long as it's in the coding set, the position matters for correct coding, but if we're doing a query, we can ask for a code, an SO6 code or a personal history code, we can ask for the system to look for it in any position. So if it's coded, we will find it. But for correct coding purposes, that sequence does matter. Over.

Thank you. One more question. How do you code multiple reported instances of prior concussion?

That's a great question. With the way that the personal history code is currently being used to code it on every event, you don't know if that means they have a personal history just from this concussion or something in the past. If you read the coding guidance about personal history codes in kind of the general non-TBI world, personal history codes are meant to be used more for that history of something that might be important to my current event. So more to come on – and possible future updates to that use of the personal history code. If we used our TBI personal history codes more like other personal history codes, we could at least capture that there was a history of a TBI in the past. Wouldn't tell you how many, but at least that there was a history of TBI in the past. But as it's being used now, it's capturing the current event and having that be a personal history. And that's the way we have to do it per the guidance right now. Over.

Thank you, Dr. Lowe. That is all the time we have for questions, so thanks everybody for submitting those questions.

Right now I just want to thank Sergeant First Class Makowski, Dr. Lowe, Ms. Gina Lambdin and Ms. Judith Aurelio for a wonderful webinar. I hope that the attendees have appreciated this and helped with all the ICD-10 coding issues that's been going on, so - .

Just want to also point out that we have the Army coding sheets also in the Files pod in the DVBIC one as well, so hopefully you can get those and see if those are helping you along in your clinics. So thank you.

After the webinar, please visit dcoe.cds.pesgce.com to complete the online CE evaluation and download or print your CE certificate or Certificate of Attendance. The online CE evaluation will be open through Thursday, November 26, 2015.

To help us improve future webinars, we encourage you to complete the feedback tool that will be open in a separate browser on your computer. To access the presentation and resource lists for this webinar, you will download them from the Files pod on the screen or at the DVBIC website at

dvbic.dcoe.mil/training/webinars. An audio recording and edited script of the closed caption will be posted to that link in approximately one week.

The Chat function will remain open for an additional ten minutes after the conclusion of the webinar to permit attendees to continue to network with each other.

The next DCOE Psychological Health webinar topic, the Detrimental Effects of Blue Light From Electronics On Sleep is scheduled for December 3, 2015 from 1:00 to 2:30 p.m. Eastern Standard Time. The next DCOE TBI webinar topic, Head to Head Study, Psychometric Comparison of Three Computerized Neuropsychological Assessment Batteries, is scheduled for December 10, 2015, from 1:00 to 2:30 p.m. Eastern Time.

Thank you again for attending, and have a great day.