# Eli's Rehab Report

## 3 Tips Help You Code Head Injury Claims

**Learn what options you have for cognitive deficits**

Scanning your ICD-9 coding manual for an appropriate diagnosis code for head injury patients can mean a headache. You probably won't find a perfect code, but here's how to get closer than ever before.

**Sort Out Minor Versus Serious Injuries**

If your physiatrist is called in to see a patient with a head injury, you need to get straight what's involved with coding these events.

**Minor injuries:** If the patient has a contusion of the head, you should use 920 **(Contusion of face, scalp, and neck except eye[s]),** but remember that a contusion, by definition, includes a bruising injury that does not break the skin. Check for exclusions in your ICD-9 book. The exclusion note for this code refers to various other codes for more significant injuries that go beyond a basic bump on the head.

When your provider doesn't document any further detail than "head injury," you should use **959.01** (Head injury, unspecified). This code also has a list of exclusions similar to 920.

**Significant injuries:** You should report codes from the 850-854 series, including 854.01 (Intracranial injury of other and unspecified nature; without mention of open intracranial wound; with no loss of consciousness), for other specific and serious injuries involving the head, such as concussions, cerebral lacerations, cerebral contusions and open wound with brain hemorrhage. This series represents very serious injuries resulting from high-energy impacts to the head. Specifically, the 854 set includes cavernous sinus and intracranial injury. "We use 854.01 for total brain injury (TBI)," says **Deborah Cox, CPC, MA**, coding consultant and supervisor at Physician Practice Management in Bangor, Maine.

**Learn the Late Effects Code**

If the patient had a brain injury more than a year ago, you should look to a late effects code. Using a late effects code creates the causal relationship between a prior injury and the current condition your provider is treating, says **Marvel Hammer, RN, CPC, CCS-P, CHCO**, owner of MJH Consulting in Denver.

An example is possibly late effects code 907.0 (Late effect of intracranial injury without mention of skull fracture). In addition, you want to code as primary the actual residual condition that the patient sees the physiatrist for, such as cognitive, neuropsych or functional changes, Hammer says.

**What it is:** A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has ended. There is no time limit on when you can use a late effect code. The residual may be apparent early, as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury. Coding of late effects generally requires two codes sequenced in the following order: first, the condition or nature of the late effect; and second, the late effect code.

Reporting acute injury codes for all of the subsequent services for the latent/residual condition from a single injury indicates that the patient has had repeated acute injuries rather than requiring treatment/care for the delayed recovery of the initial injury.

**Decide What to Do for Cognitive Deficits**

If you're wondering what to code when a traumatic brain injury causes cognitive deficits, you're not alone. "Many of our

patients have this diagnosis, but we haven't found a suitable code," says **Karen Monger**, billing manager at Virginia Commonwealth University Medical Center in Richmond. "Our provider uses 294.9 (Unspecified persistent mental disorders due to conditions classified elsewhere) quite often, but that code doesn't work well with insurance companies for the doctors."

"Coding the diagnosis 'cognitive deficit' is rather tricky because there isn't an easy link in the ICD-9 alphabetic index for that often-used term," Hammer says.

**What it is:** "Cognitive deficit" means the patient has difficulties in reasoning, judgment, intuition and memory, and lack of awareness and insight, while one definition for "cognitive impairment" is: deficiency in ability to think, perceive, reason or remember resulting in loss of ability to attend to one's daily living needs, Hammer says.

**Best bet:** You should have your providers clearly document what the patient has specific problems performing ...quot; such as memory or lack of insight.

**Option 1:** "Many of the providers I work with use the ICD-9 code range 310.1-310.9 for the cognitive impairments/deficits diagnosis. Even though these codes fall in the mental disorders section, the subsection 310.x clearly is for nonpsychotic mental disorders due to brain damage," Hammer says.

**Option 2:** Others choose to use the associated dementia code (294.8), thinking that their documentation supports a more specified diagnosis rather than the "unspecified" for 294.9. These codes, however, do fall under the section of persistent mental disorders due to conditions classified elsewhere, Hammer says.

Any codes in the mental disorders section may be problematic for some payers, but using them with the late effect code may be helpful because it paints a more appropriate picture of the patient's condition.

**Heads-up:** You'll have a new ICD-9 code coming in October (331.83, Mild cognitive impairment). But this won't be a solution for the TBI cognitive-deficit patients because the exclusions will include altered mental status (780.97), cerebral degeneration (331.0-331.9), change in mental status (780.97), cognitive deficits following (late effects of) cerebral hemorrhage or infarction (438.0), cognitive impairment due to intracranial or head injury (850-854, 959.01), cognitive impairment due to late effect of intracranial injury (907.0), dementia (290.0-290.43, 294.8), mild memory disturbance (310.8), neurologic neglect syndrome (781.8), and personality change, nonpsychotic (310.1).

**Conclusion:** "Unfortunately, you'll find no perfect code to match the diagnosis," Hammer says.