Clinical Policy: Outpatient Acquired Brain Injury Services

Reference Number: AR.CP.MP.502 Coding Implications
Last Review Date: 09/26 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

An acquired brain injury (ABI) is an injury to the brain that occurs after birth, is non-congenital and non-degenerative and prevents the normal function of the brain. These impairments may be temporary or permanent and cause partial or functional disability or psychosocial maladjustment. Brain injuries may be mild, moderate, or severe and may result in memory loss, change in personality, behavioral dysfunction, (difficulty managing anger, impaired judgment, loss of impulse control), communication impairment, mobility limitations, alcohol and substance abuse and other challenges. Traumatic Brain injury is a subset of (ABI).

Non-traumatic brain injury may be caused by stroke, heart attack, near-drowning, brain tumors, infectious diseases, prolonged high temperature, decrease or loss of oxygen to the brain, metabolic or endocrine disorders such as diabetic coma, a disease that affects blood flow to the brain, and toxic exposure from substances such as lead, pesticides, drug and alcohol abuse.

Traumatic brain injuries result from an external blow or jolt to the head or an injury that disrupts the normal function of the brain. Traumatic forces to the brain may be caused by motor vehicle collisions, falls, sports injuries, explosive blasts, gunshot wounds to the head, objects falling on the head, and sharp objects penetrating the skull. Individuals with brain injuries may be able to walk, maintain their employment and other routine functions.

This policy applies to all Arkansas health plans, Ambetter from Arkansas Health and Wellness and QualChoice commercial plans, collectively, Arkansas Health Plans. Criteria specific to a health plan will be specified.

Policy/Criteria

I. It is the policy of Arkansas Health Plans that coverage for outpatient ABI treatment is **medically necessary** for the following indications ***on initial review***, all of the following must be met:

A. Member/enrollee has diagnosis indicating non-congenital acquired brain injury occurring after birth, including and limited to:

1) Traumatic Brain Injury
2) Viral encephalitis
3) Meningitis
4) Aneurysms or vascular disease affecting the brain.
5) Cerebral Vascular Accident (Stroke)
6) Brain tumors (including post-operative) with neurological impairment
7) Anoxic or Hypoxic brain injury
8) Toxic Encephalopathies
9) Refractory Seizure disorders
10) Brain injury from metabolic or endocrine disease

B. Must meet all of the following criteria:
   1) Member is able to participate in the requested service.
   2) Services occur in a home or community setting.
   3) Services offered are being performed at the appropriate level of care.
   4) Services are not duplicative of other services.
   5) Services are not custodial care.
   6) The treatment conforms to the submitted plan of care specific to the member's diagnosed impairment or condition.
   7) Service must request to encompass the time frame required for entire treatment, not to exceed 12 months.

Note: Member/enrollee may have benefit limits for some services. Refer to the evidence of coverage and summary of benefits for any limitations.

   8) The service must be provided by a qualified health provider with experience or training in treating ABI if available in their area.

Note: If services are provided by a clinician without independent practice privileges treatment should be overseen by physician.

C. Documentation included with the request includes:
   1) Diagnoses, symptoms, complaints and/or complications indicating need for requested service with date of onset of exacerbation.
   2) Prescription or order and referring physician's signature.
   3) Assessment and clinically relevant evaluation related to service requested.
   4) Short- and long-term functional treatment goals that are specific, measurable, and attainable.
   5) Prescribed integrated program of therapies, including any social services, designed to meet the treatment objectives.
   6) Plans for continuing care, including any interdisciplinary team meetings review and modifications of the plan of care.
   7) Plans for discharge from the requested service.
   8) Treatment techniques and interventions to be used – amount, frequency, and duration required to achieve measurable goals.
   9) Plans for education of the Member/enrollee and primary caregiver, parent, or legal guardian, if applicable
      a. Documentation of family involvement in treatment plan for members who are under the age of 18 will be required for continued services.
   10) Summary of results achieved during previous periods of therapy, if applicable
   11) Potential for improvement in the member's function that is being treated by the service.
   12) For behavioral health services, documentation of family involvement in sessions will be required for members under the age of 18 for continued services.

II. It is the policy of Arkansas Health Plans that coverage for outpatient ABI treatment is **medically necessary** for the following indications ***for continued services***, all of the following conditions must be met:

A. Member/enrollees have measurable and sustained progress toward treatment and/or care planned goals as evident in the documentation. Progress notes should be included to show progress towards goals during the previously approved time period.
B. Member/enrollee does not meet discharge criteria.
C. Assessment and clinically relevant reevaluation of the need for continued services is present. Reassessment must occur at least annually if request is for 12 months.
    1) The treatment conforms to the submitted plan of care specific to the Member/enrollee's diagnosed impairment or condition.
    2) Service must request to encompass the time frame required for entire treatment, not to exceed 12 months.

Note: Member/enrollee may have benefit limits for some services. Refer to the evidence of coverage and summary of benefits for any limitations.

    3) The service must be provided by a qualified health provider with experience or training in treating ABI if available in members area.

Note: If services are** provided **by a clinician without independent practice privileges treatment should be overseen by physician.

D. The treatment plan is updated to include:
    1) Diagnoses, symptoms, complaints and complications indicating need for requested service and date of onset of exacerbation.
    2) Prescription or order and referring physician's signature, renewed at least every 12 months. Assessment and clinically relevant evaluation related to service requested.
    3) Provider reassessment should include updated objective information – physical examination and standardized functional measures/testing.
    4) Short- and long-term functional treatment goals that are specific, measurable, and attainable. **Goals should be updated to reflect the most recent evaluation and progress.**
    5) Prescribed integrated program of therapies, including any social services, designed to meet the treatment objectives.
    6) Plans for continuing care, including any interdisciplinary team meetings review and modifications of the plan of care.
    7) Plans for discharge from the requested service.
    8) Treatment techniques and interventions to be used – amount, frequency, and duration required to achieve measurable goals.
    9) Education of the Member/enrollee and primary caregiver, parent, or legal guardian, if applicable.
        a. Documentation of family involvement in treatment plan for members who are under the age of 18 is required.
    10) Summary of results achieved during previous periods of therapy, if applicable
    11) Potential for improvement in the Member/enrollees' function that is being treated by the service.
    12) For behavioral health services, documentation of family involvement in sessions is required for members under the age of 18.

III. In addition to the previous criteria, it is the policy of the Arkansas Plans that the specific services **meet medical necessity** if the following criteria are met:

A. Cognitive Rehabilitation Therapy (CRT)
   1) A Neurobehavioral Assessment must be completed by a physician, nurse practitioner or physician assistant **or** a neuropsychological assessment must be performed by a psychiatrist, psychologist, neuropsychologist or licensed psychological associate. These tests should document the Member/enrollees' need for CRT services.
   2) Services are provided by a speech therapist.

B. Cognitive Communication
   1) A cognitive communication evaluation performed by a speech therapist. Evaluation should include assessment of oral and written expression, auditory and reading comprehension, information processing, executive function, thinking, reasoning, problem-solving, and self-regulation. This assessment should document the Member/enrollees' need for cognitive communication therapy.
   2) Services are provided by a speech therapist.

C. Community Reintegration
   1) Therapy is provided by a multidisciplinary team.
   2) Treatment plan specifies clear, reasonable objectives and goals of the service.
   3) Planned services are clearly outlined in the treatment plan.

D. Functional Rehabilitation
   1) Must meet criteria for each service type as listed in treatment plan.
      a. Arkansas Health plans use InterQual criteria for this service as appropriate for the therapies as indicated in the treatment plan not listed elsewhere in this policy. (Speech Therapy, Occupational Therapy, Physical Therapy, behavioral health in outpatient setting).

E. Home and Community Based Services
   1) Must meet criteria for each service type as listed in treatment plan.
      a. Arkansas Health plans use InterQual criteria for this service as appropriate for the therapies as indicated in the treatment plan not listed elsewhere in this policy. (I.E. Home Health, Speech Therapy, Occupational Therapy, Physical Therapy, behavioral health in outpatient setting).
      b. Personal care and custodial care services are not covered for Ambetter from Arkansas Health and Wellness or QualChoice.

Note: Refer to the evidence of coverage and summary of benefits for any limitations on coverage.

F. Neurobehavioral Therapy
   1) A Neurobehavioral Assessment must be completed by a physician, nurse practitioner or physician assistant **or** a neuropsychological assessment must be performed by a psychiatrist, psychologist, neuropsychologist or licensed

psychological associate. These tests should document the Member/enrollees' need for neurobehavioral therapy.

2) Services are provided by an appropriate licensed behavioral health professional.

3) Arkansas health plans use InterQual Criteria for appropriate behavioral health care in an outpatient setting.

G. Neurocognitive Therapy

1) A Neurobehavioral Assessment must be completed by a physician, nurse practitioner or physician assistant **or** a neuropsychological assessment must be performed by a psychiatrist, psychologist, neuropsychologist or licensed psychological associate. These tests should document the Member/enrollees' need for neurocognitive therapy.

2) Services can be provided by a speech therapist or a behavioral health professional.

H. Neurofeedback

1) Comprehensive treatment plan includes biofeedback **as an adjunctive intervention i**n addition to other primary evidence-based interventions.
2) The condition can be appropriately treated with biofeedback (e.g., existing pathology does not prevent success of the treatment).
3) There is evidence that standard evidence-based outpatient treatments (including psychotherapy and medication management) are considered insufficient to treat the Member/enrollee/enrollee's condition safely and effectively.
4) There is a readily identifiable response measurable by a symptom specific validated standardized scale.
5) Biofeedback training is performed by a physician or qualified non-physician practitioner who has undergone biofeedback training and certification. This can include nurse practitioners, physician assistants, qualified mental health professionals, psychologists and, where applicable, biofeedback technicians.
6) There is documented planned transition out of biofeedback from the start of treatment, which may include ensuring the ability of the Member/enrollee to continue the biofeedback-learned techniques independently after the biofeedback sessions end.
7) It is the policy of Arkansas plans that neurofeedback is **no longer medically necessary** and discharge from treatment is medically appropriate when any one of the following are met:
   a. The documented goals and objectives have been substantially achieved.
   b. The Member/enrollee no longer meets initiation or continuation criteria, or symptom severity has dropped by 50%.
   c. Member/enrollee is not engaging in treatment, rendering biofeedback ineffective, despite multiple documented attempts to address non-participation issues.
   d. Member/enrollee refuses treatment.

e. Member/enrollee is not making progress toward treatment goals and there is no reasonable expectation of progress with this treatment approach.
f. It is reasonably predicted that continuing improvement can occur after discontinuation of biofeedback with ongoing psychotherapy, medication management and/or community support.

I. Neuropsychological Testing: Arkansas Health plans use InterQual criteria for this service.
J. Outpatient and Day Treatment Programs.
    1) Must meet criteria for each service type as listed in treatment plan.
        a. Arkansas Health plans use InterQual criteria for this service as appropriate for the therapies as indicated in the treatment plan not listed elsewhere in this policy. (Speech Therapy, Occupational Therapy, Physical Therapy, behavioral health in outpatient setting).

K. Post-Acute Care Residential Treatment in a home or community setting.
    1) Must meet criteria for each service type as listed in treatment plan.
        a. Arkansas Health plans use InterQual criteria for this service as appropriate for the therapies as indicated in the treatment plan not listed elsewhere in this policy. (Speech Therapy, Occupational Therapy, Physical Therapy, behavioral health in outpatient setting).

IV. It is the policy of Arkansas Health Plans that coverage for outpatient ABI treatment is **no longer medically necessary** and discharge from services is recommended, if one or more of the following is met, (as appropriate to the service provided):

A. Member/enrollee no longer demonstrates functional or behavioral impairment or has achieved goals set forth in the plan of care.
B. Member/enrollee has returned to baseline or optimal level of functioning.
C. Member/enrollee can continue therapy with a home treatment program that no longer requires skilled supervision, and deficits no longer require skilled therapy intervention to maintain status.
D. Member/enrollee has adapted to impairment with use of compensatory strategies or assistive equipment/devices.
E. Member/enrollee is able to perform ADLs with minimal to no assistance from caregiver, if improving skills for ADL's are part of the treatment plan.
F. Member/enrollee has achieved maximum functional or behavioral benefit from therapy or are no longer expected to benefit from additional therapy based upon lack of or minimal progress towards treatment goals.
G. Member/enrollee is unable to participate in the treatment plan due to medical, psychological, or social complications and member, caregiver, parent, or legal guardian, has had instruction on the home treatment program and the skills of a therapist are not needed to provide or supervise the service.
H. Non-compliance due to poor attendance or refusal to participate by the member/enrollee or parent/legal guardian, and/or non-compliance with therapy and home treatment program.

I. If therapy no longer appears to be clinically appropriate or beneficial to the Member/enrollee for any reason, including those identified above, a recommendation for discontinuation (denial) will be referred to the medical director for final review and determination.
    1) A full review of the Member/enrollee's complete documented therapy history may be performed. If the therapy documentation does not support appropriate or functionally beneficial skilled services, a denial recommendation may be made to the medical director.

Background

Neurocognitive Therapy

Neurocognitive therapy, often referred to as cognitive rehabilitation (CR), is a structured intervention aimed at improving cognitive functions such as attention, memory, executive function, and problem-solving in individuals with acquired brain injury (ABI), including traumatic brain injury (TBI). The therapy encompasses restorative techniques to enhance cognitive abilities and compensatory strategies to manage deficits, thereby facilitating greater independence and quality of life.

1) Evidence-Based Efficacy

A systematic review of 32 studies, including randomized controlled trials (RCTs), found that specific forms of cognitive rehabilitation can reduce memory failures, alleviate anxiety, and improve self-concept and interpersonal relationships in individuals with TBI. However, the durability and clinical relevance of these findings require further investigation.[1]

Another study evaluated an integrated neuropsychological and cognitive behavioral therapy (nCBT) approach for outpatients with ABI. The nCBT group showed significant improvements in general psychopathology, negative affect, and quality of life compared to a waitlist group. However, no significant differences were observed in functional activity and community integration, highlighting the need for comprehensive interventions that address both cognitive and emotional aspects.[2]

A meta-analytic review of cognitive language rehabilitation literature indicated that cognitive rehabilitation therapies are effective in improving language functions in individuals with TBI and stroke, with effect sizes suggesting benefits beyond spontaneous recovery.[3]

Neuropsychological Testing

Neuropsychological assessments objectively and reliably measure behavioral signs of central nervous system (CNS) disorders. These evaluations help guide medical decisions by providing data for diagnosis, tracking disease progression, predicting outcomes, and planning treatment. They also offer insight into functional abilities across various disorders and are often included in physicians' discharge summaries. Conducted within a comprehensive framework, these assessments integrate clinical interviews, medical history, behavioral observations, and when relevant, neuroimaging and other diagnostic tests to support targeted interventions.

Neurofeedback

Neurofeedback involves monitoring brain activity through electroencephalography (EEG) and providing real-time feedback to individuals, enabling them to modify their brainwave patterns. This process aims to enhance neural plasticity and improve cognitive functions such as attention, memory, and executive function, which are often impaired following TBI.

1) *Randomized Controlled Trials (RCTs)*
    - Cognitive Function and Quality of Life: A randomized controlled trial involving 87 TBI patients assessed the effects of low-resolution tomography Z-score neurofeedback (LZNFB) and theta/beta neurofeedback on cognitive function, productive activity, and quality of life. The LZNFB group exhibited significant improvements in immediate recall, delayed recall, recognition memory, and selective attention compared to the usual care group. The theta/beta neurofeedback group showed improvements in immediate memory and selective attention. Additionally, the LZNFB group reported enhanced productive activity and quality of life. [4]

    - Short-Term Memory and Attention: A preliminary randomized controlled trial with 17 patients found no significant improvement in short-term memory and continuous attention following 20 sessions of neurofeedback. However, the study's small sample size and short duration limit the generalizability of these findings.[5]

2) *Systematic Reviews and Meta-Analyses*
    - Cognitive Rehabilitation: A systematic review of four studies on neurofeedback for cognitive rehabilitation in acquired brain injury (ABI) indicated inconsistent results across studies and cognitive domains. The review highlighted methodological limitations and the need for more rigorous research to determine the efficacy of neurofeedback in ABI rehabilitation.[6]
    - Traumatic Brain Injury: A literature review encompassing 22 studies on neurofeedback for TBI symptoms reported positive findings, with improvements in attention, memory, and mood. However, the review noted the lack of placebo-controlled studies and variability in study designs, emphasizing the need for more robust research.[7]
3) *The Association for Applied Psychophysiology and Biofeedback*[8]
    - Biofeedback is NOT used as a treatment alone, nor can it be used alone to make a diagnosis. It should be used as an adjunctive tool to be combined with other standard interventions conducted by knowledgeable clinicians, educators, or coaches. Several biofeedback-based interventions have been well validated while others are at various stages of research. Many biofeedback-based interventions are accepted by medical societies such as the American Colleges of Pediatrics and Neurology as well as by the FDA as being safe and effective for conditions. The efficacy of some forms and uses of biofeedback have not yet been established through accepted types of research with enough clients, controls, and long enough follow-up periods.

Cognitive Communication therapy
Cognitive communication therapy is an evidence-based intervention aimed at improving communication abilities in individuals with brain injury. This therapy focuses on enhancing cognitive processes such as attention, memory, and executive function, which are crucial for effective communication. Research has demonstrated its efficacy in various settings, including post-acute rehabilitation and vocational training. [9]

The INCOG 2.0 guidelines for cognitive rehabilitation emphasize interventions that are individualized, functional, and context specific. Recommended strategies include:

- **Communication Partner Training**: Educating those who interact with individuals with TBI to enhance communication effectiveness.
- **Metacognitive Awareness Training**: Helping individuals recognize and regulate their cognitive processes to improve communication.
- **Reintegration to Daily Functions**: Facilitating the application of communication skills in real-life contexts to promote independence and participation. [10]

Cognitive Rehabilitation Therapy
Cognitive rehabilitation (CR) is an evidence-based therapeutic approach designed to address cognitive deficits resulting from acquired brain injury (ABI), including traumatic brain injury (TBI), stroke, and other neurological conditions. The primary goal of CR is to enhance cognitive functions such as attention, memory, executive function, and communication, thereby improving the individual's ability to perform daily activities and participate in social and vocational roles.

CR encompasses two main strategies:

- **Restorative Interventions**: Aim to directly improve impaired cognitive functions through repetitive practice and training.
- **Compensatory Strategies**: Focus on teaching individuals to use alternative methods or tools to bypass cognitive deficits, such as using memory aids or modifying tasks to reduce cognitive demands.

Effective CR programs are typically individualized, goal-oriented, and may involve both individual and group therapy sessions.

A systematic review of 95 randomized controlled trials (RCTs) involving 4,068 patients with ABI found substantial evidence supporting the efficacy of CR. The review identified 29 recommendations for evidence-based practice, including:

- **Attention Deficits**: Interventions targeting attention deficits after TBI or stroke.
- **Visual Scanning**: Training for visual scanning in cases of neglect following right-hemisphere stroke.
- **Memory Deficits**: Use of compensatory strategies for mild memory deficits.
- **Language Deficits**: Interventions for language deficits after left-hemisphere stroke.
- **Social-Communication Deficits**: Addressing social-communication deficits after TBI.
- **Executive Functioning**: Metacognitive strategy training for deficits in executive functioning.
- **Comprehensive Rehabilitation**: Holistic neuropsychological rehabilitation to reduce cognitive and functional disability after TBI or stroke.[11]

These recommendations are classified as Practice Standards, Guidelines, or Options based on the strength of the evidence.

Community Reintegration

Community reintegration is a critical aspect of rehabilitation for individuals with acquired brain injury (ABI), encompassing the process of returning to meaningful participation in home, social, and productive activities. Evidence-based approaches emphasize individualized, interdisciplinary interventions that address cognitive, emotional, and environmental factors influencing reintegration.[12]

Research identifies several factors that significantly impact community reintegration outcomes:

- **Cognitive Functioning**: Impairments in attention, memory, and executive functions can hinder participation in daily activities and social interactions.
- **Emotional and Behavioral Factors**: Mood disorders, anxiety, and behavioral issues such as impulsivity or aggression may impede social engagement and occupational performance.
- **Physical Functioning**: Mobility limitations and fatigue can restrict involvement in community activities and employment.
- **Social Support**: Strong support networks are associated with better outcomes in community reintegration.
- **Environmental Factors**: Access to transportation, community resources, and supportive living environments facilitate participation.

A scoping review of 53 studies found that cognition, disability, mobility, mood, social support, and length of posttraumatic amnesia had the strongest relationships with community integration outcomes. [13]

Effective interventions for promoting community reintegration include:

- Occupational Therapy: Therapists assist individuals in developing skills for daily living, vocational tasks, and social interactions, often through task-specific training and environmental modifications.

- Assertive Community Treatment (ACT): This intensive, team-based approach provides personalized support, including home visits and coordination of services, aiming to reduce hospitalizations and promote independence.

- Behavioral Strategies: Implementing structured programs to address challenging behaviors, such as impulsivity or aggression, through reinforcement and self-management techniques.[14]

- Technology-Assisted Interventions: Utilizing telehealth platforms, mobile applications, and virtual reality to deliver rehabilitation services, monitor progress, and enhance engagement.[15]

Functional Rehabilitation

Functional rehabilitation is a cornerstone of treatment for individuals with acquired brain injury (ABI), aiming to restore independence and enhance participation in daily life. Evidence-based approaches emphasize early, individualized, and interdisciplinary interventions tailored to the specific needs of each patient.

Functional rehabilitation encompasses various therapeutic modalities:

- Physical Therapy (PT): Focuses on improving mobility, strength, and coordination through exercises and gait training.
- Occupational Therapy (OT): Assists individuals in regaining skills necessary for daily activities, such as dressing, cooking, and bathing.
- Speech-Language Therapy (SLT): Addresses communication and swallowing difficulties, enhancing verbal and non-verbal communication skills.
- Neuropsychological Rehabilitation: Targets cognitive deficits, including attention, memory, and executive function, through structured cognitive exercises and strategies.
- Vocational Rehabilitation: Supports individuals in returning to work or finding new employment opportunities that align with their abilities.

1) *Evidence Supporting Functional Rehabilitation*

A study on community-based rehabilitation for adults with moderate-to-severe ABI reported significant improvements in physical and psychosocial functioning immediately following rehabilitation, with medium-to-large effect sizes on the Mayo-Portland Adaptability Inventory (MPAI-4) subscales. However, a decline in adjustment was noted at the 3-year follow-up, highlighting the need for continued support.[16]

Research indicates that early initiation of neurorehabilitation, particularly in trauma centers, and more intensive rehabilitation in post-acute settings promote functional recovery. A study comparing early versus delayed rehabilitation groups found that early rehabilitation was associated with better outcomes on the Glasgow Outcome Scale and Disability Rating Scale at 12 months post-injury.[17]

Additionally, a retrospective case-matched study of a functionally based neurorehabilitation program for individuals with traumatic brain injury (TBI) demonstrated that patients in the neurophysical stream had significantly higher Functional Independence Measure (FIM) motor efficiency compared to controls, and those in the neurocognitive stream exhibited less disability at discharge.[18]

2) Best Practices in Functional Rehabilitation

- Early and Intensive Intervention: Initiating rehabilitation as soon as medically feasible and providing intensive therapy are crucial for optimal recovery.
- Individualized Treatment Plans: Tailoring interventions to the specific needs, goals, and preferences of each patient enhances engagement and outcomes.
- Interdisciplinary Collaboration: Coordinated care among a team of professionals, including physicians, therapists, and neuropsychologists, ensures comprehensive treatment.
- Community Integration: Incorporating real-life contexts and environments into therapy facilitates the transfer of skills and promotes independence.

3) Long-Term Considerations

While significant improvements can be achieved during the rehabilitation phase, long-term follow-up is essential to address ongoing challenges and support sustained recovery. Continued access to community resources, vocational support, and mental health services plays a vital role in maintaining functional gains and enhancing quality of life.

Functional rehabilitation is a dynamic and patient-centered process that requires commitment to individualized care, ongoing assessment, and adaptation to the evolving needs of individuals with acquired brain injury. By adhering to evidence-based practices and fostering a supportive environment, clinicians can significantly impact the recovery trajectory and overall well-being of their patients.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
96116	Nubhvl xm phys/qhp 1st hr
96121	Nubhvl xm phy/qhp ea addl hr

CPT® Codes	Description
96125	Cognitive test by hc pro
96136	Psycl/nrpsyc tst phy/qhp 1st
96137	Psycl/nrpsyc tst phy/qhp ea
96138	Psycl/nrpsyc tech 1st
96139	Psycl/nrpsyc tst tech ea
90901	Biofeedback training by any modality
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)
92521	Evaluation of speech fluency (eg, stuttering, cluttering)
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)
92609	Therapeutic services for the use of speech-generating device, including programming and modification
92610	Evaluation of oral and pharyngeal swallowing function

CPT® Codes	Description
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording
92612	Flexible endoscopic evaluation of swallowing by cine or video recording
92614	Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording
92616	Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
95852	Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side
95992	Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day
96000	Comprehensive computer-based motion analysis by video-taping and 3D kinematics
96001	Comprehensive computer-based motion analysis by video-taping and 3-D kinematics: with dynamic plantar pressure measurements during walking
96002	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises

CPT® Codes	Description
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97139	Unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.

CPT® Codes	Description
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.

CPT® Codes	Description
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.

CPT® Codes	Description
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes

CPT® Codes	Description
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening, each additional hour (List separately in addition to code for primary procedure)
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; each additional 15 minutes
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers.
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with a written report, every 15 minutes
97755	Assistive technology assessment (e.g., to restore, compensate for an existing function or augment, optimize functional tasks and / or maximize environmental accessibility), direct one-on-one contact with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/Prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure

CPT® Codes	Description
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.
98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-12 minutes
98972	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
98975	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment.
98976	Remote therapeutic monitoring device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
98977	Remote therapeutic monitoring device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days

CPT® Codes	Description
98980	Remote therapeutic monitoring treatment management, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes.
98981	Remote therapeutic monitoring treatment management, physician/other qualified health care professional time in a calendar month; each additional 20 minutes

HCPCS Codes	Description
G0541	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes
G0542	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service) (use g0542 in conjunction with g0541)
G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion

ICD-10-CM Diagnosis Codes that May Support Coverage Criteria[19]

+ Indicates a code requiring an additional character.

ICD-10-CM Code	Description
T36.0+ through T36.5+	Poisoning and toxic effects supported by documentation of resulting acquired brain injury.
S0990XA	Unspecified injury of head, initial encounter

ICD-10-CM Code	Description
S0990XD	Unspecified injury of head, subsequent encounter
S0990XS	Unspecified injury of head, sequela
S028XXA	Fractures of oth skull and facial bones, init for clos fx
S028XXB	Fractures of oth skull and facial bones, init for opn fx
S028XXD	Fracture of oth skull and facial bones, subs for fx w routn heal
S028XXG	Fracture of oth skull and facial bones, subs for fx w delay heal
S028XXK	Fracture of oth skull and facial bones, subs for fx w nonunion
S028XXS	Fractures of other specified skull and facial bones, sequela
S0291XA	Unsp fracture of skull, init encntr for closed fracture
S0291XB	Unspecified fracture of skull, init encntr for open fracture
S0291XD	Unsp fracture of skull, subs for fx w routn heal
S0291XG	Unsp fracture of skull, subs for fx w delay heal
S0291XK	Unsp fracture of skull, subs encntr for fracture w nonunion
S0291XS	Unspecified fracture of skull, sequela

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
A0101	Typhoid meningitis
A0221	Salmonella meningitis
A066	Amebic brain abscess
A170	Tuberculous meningitis
A1782	Tuberculous meningoencephalitis
A203	Plague meningitis
A2781	Aseptic meningitis in leptospirosis
A3211	Listerial meningitis
A3212	Listerial meningoencephalitis
A390	Meningococcal meningitis
A392	Acute meningococcemia
A393	Chronic meningococcemia
A3981	Meningococcal encephalitis
A4281	Actinomycotic meningitis
A4282	Actinomycotic encephalitis
A5041	Late congenital syphilitic meningitis
A5042	Late congenital syphilitic encephalitis
A5141	Secondary syphilitic meningitis
A5213	Late syphilitic meningitis
A5214	Late syphilitic encephalitis
A5481	Gonococcal meningitis
A5482	Gonococcal brain abscess

ICD-10-CM Code	Description
A6921	Meningitis due to Lyme disease
A811	Subacute sclerosing panencephalitis
A812	Progressive multifocal leukoencephalopathy
A830	Japanese encephalitis
A831	Western equine encephalitis
A832	Eastern equine encephalitis
A833	St Louis encephalitis
A834	Australian encephalitis
A835	California encephalitis
A838	Other mosquito-borne viral encephalitis
A839	Mosquito-borne viral encephalitis, unspecified
A840	Far Eastern tick-borne encephalitis
A841	Central European tick-borne encephalitis
A848	Other tick-borne viral encephalitis
A8489	Other tick-borne viral encephalitis
A849	Tick-borne viral encephalitis, unspecified
A850	Enteroviral encephalitis
A851	Adenoviral encephalitis
A852	Arthropod-borne viral encephalitis, unspecified
A858	Other specified viral encephalitis
A86	Unspecified viral encephalitis
A870	Enteroviral meningitis
A871	Adenoviral meningitis
A872	Lymphocytic choriomeningitis
A878	Other viral meningitis
A879	Viral meningitis, unspecified
A9231	West Nile virus infection with encephalitis
B003	Herpesviral meningitis
B004	Herpesviral encephalitis
B010	Varicella meningitis
B0111	Varicella encephalitis and encephalomyelitis
B020	Zoster encephalitis
B021	Zoster meningitis
B050	Measles complicated by encephalitis
B051	Measles complicated by meningitis
B0601	Rubella encephalitis
B0602	Rubella meningitis
B1001	Human herpesvirus 6 encephalitis
B1009	Other human herpesvirus encephalitis

ICD-10-CM Code	Description
B261	Mumps meningitis
B262	Mumps encephalitis
B2702	Gammaherpesviral mononucleosis with meningitis
B2712	Cytomegaloviral mononucleosis with meningitis
B2782	Other infectious mononucleosis with meningitis
B2792	Infectious mononucleosis, unspecified with meningitis
B375	Candidal meningitis
B384	Coccidioidomycosis meningitis
B4081	Blastomycotic meningoencephalitis
B4281	Cerebral sporotrichosis
B431	Pheomycotic brain abscess
B451	Cerebral cryptococcosis
B461	Rhinocerebral mucormycosis
B500	Plasmodium falciparum malaria with cerebral complications
B5741	Meningitis in Chagas' disease
B5742	Meningoencephalitis in Chagas' disease
B582	Toxoplasma meningoencephalitis
B6011	Meningoencephalitis due to Acanthamoeba (culbertsoni)
B941	Sequelae of viral encephalitis
C700	Malignant neoplasm of cerebral meninges
C701	Malignant neoplasm of spinal meninges
C709	Malignant neoplasm of meninges, unspecified
C710	Malignant neoplasm of cerebrum, except lobes and ventricles
C711	Malignant neoplasm of frontal lobe
C712	Malignant neoplasm of temporal lobe
C713	Malignant neoplasm of parietal lobe
C714	Malignant neoplasm of occipital lobe
C715	Malignant neoplasm of cerebral ventricle
C716	Malignant neoplasm of cerebellum
C717	Malignant neoplasm of brain stem
C718	Malignant neoplasm of overlapping sites of brain
C719	Malignant neoplasm of brain, unspecified
C751	Malignant neoplasm of pituitary gland
C752	Malignant neoplasm of craniopharyngeal duct
C753	Malignant neoplasm of pineal gland
C7931	Secondary malignant neoplasm of brain
C7932	Secondary malignant neoplasm of cerebral meninges
D320	Benign neoplasm of cerebral meninges
D321	Benign neoplasm of spinal meninges

ICD-10-CM Code	Description
D329	Benign neoplasm of meninges, unspecified
D330	Benign neoplasm of brain, supratentorial
D331	Benign neoplasm of brain, infratentorial
D332	Benign neoplasm of brain, unspecified
D339	Benign neoplasm of central nervous system, unspecified
D352	Benign neoplasm of pituitary gland
D353	Benign neoplasm of craniopharyngeal duct
D354	Benign neoplasm of pineal gland
D420	Neoplasm of uncertain behavior of cerebral meninges
D429	Neoplasm of uncertain behavior of meninges, unspecified
D430	Neoplasm of uncertain behavior of brain, supratentorial
D431	Neoplasm of uncertain behavior of brain, infratentorial
D432	Neoplasm of uncertain behavior of brain, unspecified
D439	Neoplasm of uncertain behavior of cnsl, unsp
D443	Neoplasm of uncertain behavior of pituitary gland
D444	Neoplasm of uncertain behavior of craniopharyngeal duct
D445	Neoplasm of uncertain behavior of pineal gland
D8681	Sarcoid meningitis
E512	Wernicke's encephalopathy
G000	Hemophilus meningitis
G001	Pneumococcal meningitis
G002	Streptococcal meningitis
G003	Staphylococcal meningitis
G008	Other bacterial meningitis
G009	Bacterial meningitis, unspecified
G01	Meningitis in bacterial diseases classified elsewhere
G02	Meningitis in oth infec/parastc diseases classd elswhr
G030	Nonpyogenic meningitis
G031	Chronic meningitis
G032	Benign recurrent meningitis [Mollaret]
G038	Meningitis due to other specified causes
G039	Meningitis, unspecified
G0400	Acute disseminated encephalitis and encephalomyelitis, unsp
G0401	Postinfect acute dissem encephalitis and encephalomyelitis
G0402	Postimmun ac dissem encphlts, myelitis and encephalomyelitis
G042	Bacterial meningoencephalitis and meningomyelitis, NEC
G0430	Acute necrotizing hemorrhagic encephalopathy, unspecified
G0431	Postinfectious acute necrotizing hemorrhagic encephalopathy
G0432	Postimmun acute necrotizing hemorrhagic encephalopathy
G0439	Other acute necrotizing hemorrhagic encephalopathy

ICD-10-CM Code	Description
G0481	Other encephalitis and encephalomyelitis
G0490	Encephalitis and encephalomyelitis, unspecified
G053	Encephalitis and encephalomyelitis in diseases classd elswhr
G060	Intracranial abscess and granuloma
G062	Extradural and subdural abscess, unspecified
G213	Postencephalitic parkinsonism
G361	Acute and subacute hemorrhagic leukoencephalitis [Hurst]
G910	Communicating hydrocephalus
G911	Obstructive hydrocephalus
G912	(Idiopathic) normal pressure hydrocephalus
G913	Post-traumatic hydrocephalus, unspecified
G914	Hydrocephalus in diseases classified elsewhere
G918	Other hydrocephalus
G919	Hydrocephalus, unspecified
G92	Toxic encephalopathy
G928	Other toxic encephalopathy
G929	Unspecified toxic encephalopathy
G930	Cerebral cysts
G931	Anoxic brain damage, not elsewhere classified
G9332	Myalgic encephalomyelitis/chronic fatigue syndrome
G9340	Encephalopathy, unspecified
G9341	Metabolic encephalopathy
G9342	Megalencephalic leukoencephalopathy with subcortical cysts
G9343	Leukoencephalopathy with calcifications and cysts
G9345	Developmental and epileptic encephalopathy
G9349	Other encephalopathy
G936	Cerebral edema
G9612	Meningeal adhesions (cerebral) (spinal)
I6000	Ntrm subarach hemorrhage from unsp carotid siphon and bifurc
I6001	Ntrm subarach hemor from right carotid siphon and bifurc
I6002	Ntrm subarach hemorrhage from left carotid siphon and bifurc
I6010	Ntrm subarach hemorrhage from unsp middle cerebral artery
I6011	Ntrm subarach hemorrhage from right middle cerebral artery
I6012	Ntrm subarach hemorrhage from left middle cerebral artery
I602	Ntrm subarach hemorrhage from anterior communicating artery
I6020	Ntrm subarach hemor from unsp anterior communicating artery
I6021	Ntrm subarach hemor from right anterior communicating artery
I6022	Ntrm subarach hemor from left anterior communicating artery
I6030	Ntrm subarach hemor from unsp posterior communicating artery
I6031	Ntrm subarach hemor from right post communicating artery

ICD-10-CM Code	Description
I6032	Ntrm subarach hemor from left posterior communicating artery
I604	Nontraumatic subarachnoid hemorrhage from basilar artery
I6050	Nontraumatic subarachnoid hemorrhage from unsp verteb art
I6051	Nontraumatic subarachnoid hemorrhage from r verteb art
I6052	Nontraumatic subarachnoid hemorrhage from l verteb art
I606	Nontraumatic subarachnoid hemorrhage from oth intracran art
I607	Nontraumatic subarachnoid hemorrhage from unsp intracran art
I608	Other nontraumatic subarachnoid hemorrhage
I609	Nontraumatic subarachnoid hemorrhage, unspecified
I610	Nontraumatic intcrbl hemorrhage in hemisphere, subcortical
I611	Nontraumatic intcrbl hemorrhage in hemisphere, cortical
I612	Nontraumatic intracerebral hemorrhage in hemisphere, unsp
I613	Nontraumatic intracerebral hemorrhage in brain stem
I614	Nontraumatic intracerebral hemorrhage in cerebellum
I615	Nontraumatic intracerebral hemorrhage, intraventricular
I616	Nontraumatic intracerebral hemorrhage, multiple localized
I618	Other nontraumatic intracerebral hemorrhage
I619	Nontraumatic intracerebral hemorrhage, unspecified
I6200	Nontraumatic subdural hemorrhage, unspecified
I6201	Nontraumatic acute subdural hemorrhage
I6202	Nontraumatic subacute subdural hemorrhage
I6203	Nontraumatic chronic subdural hemorrhage
I621	Nontraumatic extradural hemorrhage
I629	Nontraumatic intracranial hemorrhage, unspecified
I6300	Cerebral infarction due to thombos unsp precerebral artery
I63011	Cerebral infarction due to thrombosis of r verteb art
I63012	Cerebral infarction due to thrombosis of l verteb art
I63013	Cerebral infrc due to thrombosis of bilateral verteb art
I63019	Cerebral infarction due to thombos unsp vertebral artery
I6302	Cerebral infarction due to thrombosis of basilar artery
I63031	Cerebral infrc due to thrombosis of right carotid artery
I63032	Cerebral infarction due to thrombosis of left carotid artery
I63033	Cerebral infrc due to thombos of bilateral carotid arteries
I63039	Cerebral infarction due to thrombosis of unsp carotid artery
I6309	Cerebral infarction due to thrombosis of precerebral artery
I6310	Cerebral infarction due to embolism of unsp precerb artery
I63111	Cerebral infarction due to embolism of r verteb art
I63112	Cerebral infarction due to embolism of left vertebral artery
I63113	Cerebral infarction due to embolism of unsp vertebral artery
I63119	Cerebral infarction due to embolism of unsp vertebral artery

ICD-10-CM Code	Description
I6312	Cerebral infarction due to embolism of basilar artery
I63131	Cerebral infarction due to embolism of right carotid artery
I63132	Cerebral infarction due to embolism of left carotid artery
I63133	Cerebral infrc due to embolism of bilateral carotid arteries
I63139	Cerebral infarction due to embolism of unsp carotid artery
I6319	Cerebral infarction due to embolism of precerebral artery
I6320	Cereb infrc due to unsp occls or stenos of unsp precerb art
I63211	Cereb infrc due to unsp occls or stenos of right verteb art
I63212	Cereb infrc due to unsp occls or stenosis of left verteb art
I63213	Cereb infrc due to unsp occls or stenosis of bi verteb art
I63219	Cereb infrc due to unsp occls or stenosis of unsp verteb art
I6322	Cerebral infrc due to unsp occls or stenosis of basilar art
I63231	Cereb infrc due to unsp occls or stenos of right carotid art
I63232	Cereb infrc due to unsp occls or stenos of left carotid art
I63233	Cereb infrc due to unsp occls or stenosis of bi carotid art
I63239	Cereb infrc due to unsp occls or stenos of unsp crtd artery
I6329	Cerebral infrc due to unsp occls or stenosis of precerb art
I6330	Cerebral infarction due to thombos unsp cerebral artery
I63311	Cereb infrc due to thombos of right middle cerebral artery
I63312	Cerebral infrc due to thombos of left middle cerebral artery
I63313	Cerebral infrc due to thombos of bi middle cerebral arteries
I63319	Cerebral infrc due to thombos unsp middle cerebral artery
I63321	Cerebral infrc due to thombos of right ant cerebral artery
I63322	Cerebral infrc due to thombos of left ant cerebral artery
I63323	Cerebral infrc due to thombos of bilateral ant cerebral arteries
I63329	Cerebral infrc due to thombos unsp anterior cerebral artery
I63331	Cerebral infrc due to thombos of right post cerebral artery
I63332	Cerebral infrc due to thombos of left post cerebral artery
I63333	Cerebral infrc due to thombos of bi post cerebral arteries
I63339	Cerebral infrc due to thombos unsp posterior cerebral artery
I63341	Cerebral infrc due to thrombosis of right cereblr artery
I63342	Cerebral infarction due to thrombosis of left cereblr artery
I63343	Cerebral infrc due to thombos of bilateral cereblr arteries
I63349	Cerebral infarction due to thombos unsp cerebellar artery
I6339	Cerebral infarction due to thrombosis of oth cerebral artery
I6340	Cerebral infarction due to embolism of unsp cerebral artery
I63411	Cereb infrc due to embolism of right middle cerebral artery
I63412	Cereb infrc due to embolism of left middle cerebral artery
I63413	Cerebral infrc due to embolism of bi middle cerebral art
I63419	Cereb infrc due to embolism of unsp middle cerebral artery

ICD-10-CM Code	Description
I63421	Cerebral infrc due to embolism of right ant cerebral artery
I63422	Cerebral infrc due to embolism of left ant cerebral artery
I63423	Cerebral infrc due to embolism of bi ant cerebral arteries
I63429	Cerebral infrc due to embolism of unsp ant cerebral artery
I63431	Cerebral infrc due to embolism of right post cerebral artery
I63432	Cerebral infrc due to embolism of left post cerebral artery
I63433	Cerebral infrc due to embolism of bi post cerebral arteries
I63439	Cerebral infrc due to embolism of unsp post cerebral artery
I63441	Cerebral infarction due to embolism of right cereblr artery
I63442	Cerebral infarction due to embolism of left cereblr artery
I63443	Cerebral infrc due to embolism of bilateral cereblr arteries
I63449	Cerebral infarction due to embolism of unsp cereblr artery
I6349	Cerebral infarction due to embolism of other cerebral artery
I6350	Cereb infrc due to unsp occls or stenos of unsp cereb artery
I63511	Cereb infrc d/t unsp occls or stenos of right mid cereb art
I63512	Cereb infrc d/t unsp occls or stenos of left mid cereb art
I63513	Cereb infrc due to unsp occls or stenos of bi mid cereb art
I63519	Cereb infrc d/t unsp occls or stenos of unsp mid cereb art
I63521	Cereb infrc d/t unsp occls or stenos of right ant cereb art
I63522	Cereb infrc d/t unsp occls or stenos of left ant cereb art
I63523	Cerebral infrc due to unsp occls or stenos of bi ant cereb art
I63529	Cereb infrc d/t unsp occls or stenos of unsp ant cereb art
I63531	Cereb infrc d/t unsp occls or stenos of right post cereb art
I63532	Cereb infrc d/t unsp occls or stenos of left post cereb art
I63533	Cerebral infrc due to unsp occls or stenos of bi post cereb art
I63539	Cereb infrc d/t unsp occls or stenos of unsp post cereb art
I63541	Cereb infrc due to unsp occls or stenos of right cereblr art
I63542	Cereb infrc due to unsp occls or stenos of left cereblr art
I63543	Cereb infrc due to unsp occls or stenosis of bi cereblr art
I63549	Cereb infrc due to unsp occls or stenos of unsp cereblr art
I6359	Cereb infrc due to unsp occls or stenosis of cerebral artery
I636	Cerebral infrc due to cerebral venous thombos, nonpyogenic
I638	Other cerebral infarction
I6381	Other cereb infrc due to occls or stenosis of small artery
I6389	Other cerebral infarction
I639	Cerebral infarction, unspecified
I6501	Occlusion and stenosis of right vertebral artery
I6502	Occlusion and stenosis of left vertebral artery
I6503	Occlusion and stenosis of bilateral vertebral arteries
I6509	Occlusion and stenosis of unspecified vertebral artery

ICD-10-CM Code	Description
I651	Occlusion and stenosis of basilar artery
I6521	Occlusion and stenosis of right carotid artery
I6522	Occlusion and stenosis of left carotid artery
I6523	Occlusion and stenosis of bilateral carotid arteries
I6529	Occlusion and stenosis of unspecified carotid artery
I658	Occlusion and stenosis of other precerebral arteries
I659	Occlusion and stenosis of unspecified precerebral artery
I6601	Occlusion and stenosis of right middle cerebral artery
I6602	Occlusion and stenosis of left middle cerebral artery
I6603	Occlusion and stenosis of bilateral middle cerebral arteries
I6609	Occlusion and stenosis of unspecified middle cerebral artery
I6611	Occlusion and stenosis of right anterior cerebral artery
I6612	Occlusion and stenosis of left anterior cerebral artery
I6613	Occlusion and stenosis of bi anterior cerebral arteries
I6619	Occlusion and stenosis of unsp anterior cerebral artery
I6621	Occlusion and stenosis of right posterior cerebral artery
I6622	Occlusion and stenosis of left posterior cerebral artery
I6623	Occlusion and stenosis of bi posterior cerebral arteries
I6629	Occlusion and stenosis of unsp posterior cerebral artery
I663	Occlusion and stenosis of cerebellar arteries
I668	Occlusion and stenosis of other cerebral arteries
I669	Occlusion and stenosis of unspecified cerebral artery
I670	Dissection of cerebral arteries, nonruptured
I671	Cerebral aneurysm, nonruptured
I672	Cerebral atherosclerosis
I673	Progressive vascular leukoencephalopathy
I674	Hypertensive encephalopathy
I675	Moyamoya disease
I676	Nonpyogenic thrombosis of intracranial venous system
I677	Cerebral arteritis, not elsewhere classified
I6781	Acute cerebrovascular insufficiency
I6782	Cerebral ischemia
I6783	Posterior reversible encephalopathy syndrome
I67841	Reversible cerebrovascular vasoconstriction syndrome
I67848	Other cerebrovascular vasospasm and vasoconstriction
I67850	Cereb autosom dom artopath w subcort infarcts & leukoenceph
I67858	Other hereditary cerebrovascular disease
I6789	Other cerebrovascular disease
I679	Cerebrovascular disease, unspecified
I680	Cerebral amyloid angiopathy

ICD-10-CM Code	Description
I682	Cerebral arteritis in other diseases classified elsewhere
I688	Oth cerebrovascular disorders in diseases classd elswhr
I6900	Unspecified sequelae of nontraumatic subarachnoid hemorrhage
I6901	Cognitive deficits following ntrm subarachnoid hemorrhage
I69010	Attn and concentration deficit following ntrm subarach hemor
I69011	Memory deficit following ntrm subarachnoid hemorrhage
I69012	Vis def/sptl nglct following ntrm subarachnoid hemorrhage
I69013	Psychomotor deficit following ntrm subarachnoid hemorrhage
I69014	Fntl lb and exec fcn def following ntrm subarach hemorrhage
I69015	Cognitive social or emo def following ntrm subarach hemor
I69018	Other symp and signs w cogn fnctns fol ntrm subarach hemor
I69019	Unsp symp and signs w cogn fnctns fol ntrm subarach hemor
I69020	Aphasia following nontraumatic subarachnoid hemorrhage
I69021	Dysphasia following nontraumatic subarachnoid hemorrhage
I69022	Dysarthria following nontraumatic subarachnoid hemorrhage
I69023	Fluency disorder following ntrm subarachnoid hemorrhage
I69028	Oth speech/lang deficits following ntrm subarach hemorrhage
I69031	Monoplg upr lmb fol ntrm subarach hemor aff right dom side
I69032	Monoplg upr lmb fol ntrm subarach hemor aff left dom side
I69033	Monoplg upr lmb fol ntrm subarach hemor aff r nondom side
I69034	Monoplg upr lmb fol ntrm subarach hemor aff left nondom side
I69039	Monoplg upr lmb following ntrm subarach hemor aff unsp side
I69041	Monoplg low lmb fol ntrm subarach hemor aff right dom side
I69042	Monoplg low lmb fol ntrm subarach hemor aff left dom side
I69043	Monoplg low lmb fol ntrm subarach hemor aff r nondom side
I69044	Monoplg low lmb fol ntrm subarach hemor aff left nondom side
I69049	Monoplg low lmb following ntrm subarach hemor aff unsp side
I69051	Hemiplga fol ntrm subarach hemor aff right dominant side
I69052	Hemiplga fol ntrm subarach hemor aff left dominant side
I69053	Hemiplga following ntrm subarach hemor aff right nondom side
I69054	Hemiplga following ntrm subarach hemor aff left nondom side
I69059	Hemiplga following ntrm subarach hemor affecting unsp side
I69061	Oth parlyt synd fol ntrm subarach hemor aff right dom side
I69062	Oth parlyt synd fol ntrm subarach hemor aff left dom side
I69063	Oth parlyt synd fol ntrm subarach hemor aff r nondom side
I69064	Oth parlyt synd fol ntrm subarach hemor aff left nondom side
I69065	Oth paralytic syndrome following ntrm subarach hemor, bi
I69069	Oth paralytic syndrome fol ntrm subarach hemor aff unsp side
I69090	Apraxia following nontraumatic subarachnoid hemorrhage
I69091	Dysphagia following nontraumatic subarachnoid hemorrhage

ICD-10-CM Code	Description
I69092	Facial weakness following ntrm subarachnoid hemorrhage
I69093	Ataxia following nontraumatic subarachnoid hemorrhage
I69098	Oth sequelae following nontraumatic subarachnoid hemorrhage
I6910	Unsp sequelae of nontraumatic intracerebral hemorrhage
I6911	Cognitive deficits following nontraumatic intcrbl hemorrhage
I69110	Attn and concentration deficit following ntrm intcrbl hemor
I69111	Memory deficit following nontraumatic intcrbl hemorrhage
I69112	Vis def/sptl nglct following nontraumatic intcrbl hemorrhage
I69113	Psychomotor deficit following ntrm intcrbl hemorrhage
I69114	Fntl lb and exec fcn def following ntrm intcrbl hemorrhage
I69115	Cognitive social or emo def following ntrm intcrbl hemor
I69118	Other symp and signs w cogn fnctns fol ntrm intcrbl hemor
I69119	Unsp symptoms and signs w cogn fnctns fol ntrm intcrbl hemor
I69120	Aphasia following nontraumatic intracerebral hemorrhage
I69121	Dysphasia following nontraumatic intracerebral hemorrhage
I69122	Dysarthria following nontraumatic intracerebral hemorrhage
I69123	Fluency disorder following nontraumatic intcrbl hemorrhage
I69128	Oth speech/lang deficits following ntrm intcrbl hemorrhage
I69131	Monoplg upr lmb fol ntrm intcrbl hemor aff right dom side
I69132	Monoplg upr lmb fol ntrm intcrbl hemor aff left dom side
I69133	Monoplg upr lmb fol ntrm intcrbl hemor aff right nondom side
I69134	Monoplg upr lmb fol ntrm intcrbl hemor aff left nondom side
I69139	Monoplg upr lmb following ntrm intcrbl hemor aff unsp side
I69141	Monoplg low lmb fol ntrm intcrbl hemor aff right dom side
I69142	Monoplg low lmb fol ntrm intcrbl hemor aff left dom side
I69143	Monoplg low lmb fol ntrm intcrbl hemor aff right nondom side
I69144	Monoplg low lmb fol ntrm intcrbl hemor aff left nondom side
I69149	Monoplg low lmb following ntrm intcrbl hemor aff unsp side
I69151	Hemiplga fol ntrm intcrbl hemor aff right dominant side
I69152	Hemiplga following ntrm intcrbl hemor aff left dominant side
I69153	Hemiplga following ntrm intcrbl hemor aff right nondom side
I69154	Hemiplga following ntrm intcrbl hemor aff left nondom side
I69159	Hemiplga following ntrm intcrbl hemor affecting unsp side
I69161	Oth parlyt synd fol ntrm intcrbl hemor aff right dom side
I69162	Oth parlyt syndrome fol ntrm intcrbl hemor aff left dom side
I69163	Oth parlyt synd fol ntrm intcrbl hemor aff right nondom side
I69164	Oth parlyt synd fol ntrm intcrbl hemor aff left nondom side
I69165	Oth paralytic syndrome following ntrm intcrbl hemor, bi
I69169	Oth paralytic syndrome fol ntrm intcrbl hemor aff unsp side
I69190	Apraxia following nontraumatic intracerebral hemorrhage

ICD-10-CM Code	Description
I69191	Dysphagia following nontraumatic intracerebral hemorrhage
I69192	Facial weakness following nontraumatic intcrbl hemorrhage
I69193	Ataxia following nontraumatic intracerebral hemorrhage
I69198	Other sequelae of nontraumatic intracerebral hemorrhage
I6920	Unsp sequelae of other nontraumatic intracranial hemorrhage
I6921	Cognitive deficits following oth ntrm intcrn hemorrhage
I69210	Attn and concentration deficit fol other ntrm intcrn hemor
I69211	Memory deficit following other ntrm intcrn hemorrhage
I69212	Vis def/sptl nglct following other ntrm intcrn hemorrhage
I69213	Psychomotor deficit following other ntrm intcrn hemorrhage
I69214	Fntl lb and exec fcn def following other ntrm intcrn hemor
I69215	Cognitive social or emo def fol other ntrm intcrn hemor
I69218	Oth symp and signs w cogn fnctns fol other ntrm intcrn hemor
I69219	Unsp symp and signs w cogn fnctns fol oth ntrm intcrn hemor
I69220	Aphasia following other nontraumatic intracranial hemorrhage
I69221	Dysphasia following oth nontraumatic intracranial hemorrhage
I69222	Dysarthria following oth nontraumatic intcrn hemorrhage
I69223	Fluency disorder following oth ntrm intcrn hemorrhage
I69228	Oth speech/lang deficits following oth ntrm intcrn hemor
I69231	Monoplg upr lmb fol oth ntrm intcrn hemor aff right dom side
I69232	Monoplg upr lmb fol oth ntrm intcrn hemor aff left dom side
I69233	Monoplg upr lmb fol oth ntrm intcrn hemor aff r nondom side
I69234	Monoplg upr lmb fol oth ntrm intcrn hemor aff l nondom side
I69239	Monoplg upr lmb fol oth ntrm intcrn hemor aff unsp side
I69241	Monoplg low lmb fol oth ntrm intcrn hemor aff right dom side
I69242	Monoplg low lmb fol oth ntrm intcrn hemor aff left dom side
I69243	Monoplg low lmb fol oth ntrm intcrn hemor aff r nondom side
I69244	Monoplg low lmb fol oth ntrm intcrn hemor aff l nondom side
I69249	Monoplg low lmb fol oth ntrm intcrn hemor aff unsp side
I69251	Hemiplga fol oth ntrm intcrn hemor aff right dominant side
I69252	Hemiplga fol oth ntrm intcrn hemor aff left dominant side
I69253	Hemiplga fol oth ntrm intcrn hemor aff right nondom side
I69254	Hemiplga fol oth ntrm intcrn hemor aff left nondom side
I69259	Hemiplga following oth ntrm intcrn hemor affecting unsp side
I69261	Oth parlyt synd fol oth ntrm intcrn hemor aff right dom side
I69262	Oth parlyt synd fol oth ntrm intcrn hemor aff left dom side
I69263	Oth parlyt synd fol oth ntrm intcrn hemor aff r nondom side
I69264	Oth parlyt synd fol oth ntrm intcrn hemor aff l nondom side
I69265	Oth paralytic syndrome following oth ntrm intcrn hemor, bi
I69269	Oth parlyt syndrome fol oth ntrm intcrn hemor aff unsp side

ICD-10-CM Code	Description
I69290	Apraxia following other nontraumatic intracranial hemorrhage
I69291	Dysphagia following oth nontraumatic intracranial hemorrhage
I69292	Facial weakness following oth nontraumatic intcrn hemorrhage
I69293	Ataxia following other nontraumatic intracranial hemorrhage
I69298	Other sequelae of other nontraumatic intracranial hemorrhage
I6930	Unspecified sequelae of cerebral infarction
I6931	Cognitive deficits following cerebral infarction
I69310	Attention and concentration deficit following cerebral infrc
I69311	Memory deficit following cerebral infarction
I69312	Vis def/sptl nglct following cerebral infarction
I69313	Psychomotor deficit following cerebral infarction
I69314	Frontal lobe and exec fcn def following cerebral infarction
I69315	Cognitive social or emo def following cerebral infarction
I69318	Other symptoms and signs w cogn fnctns fol cerebral infrc
I69319	Unsp symptoms and signs w cogn fnctns fol cerebral infrc
I69320	Aphasia following cerebral infarction
I69321	Dysphasia following cerebral infarction
I69322	Dysarthria following cerebral infarction
I69323	Fluency disorder following cerebral infarction
I69328	Oth speech/lang deficits following cerebral infarction
I69331	Monoplg upr lmb fol cerebral infrc aff right dominant side
I69332	Monoplg upr lmb fol cerebral infrc aff left dominant side
I69333	Monoplg upr lmb fol cerebral infrc aff right nondom side
I69334	Monoplg upr lmb fol cerebral infrc aff left nondom side
I69339	Monoplg upr lmb following cerebral infrc affecting unsp side
I69341	Monoplg low lmb fol cerebral infrc aff right dominant side
I69342	Monoplg low lmb fol cerebral infrc aff left dominant side
I69343	Monoplg low lmb fol cerebral infrc aff right nondom side
I69344	Monoplg low lmb fol cerebral infrc aff left nondom side
I69349	Monoplg low lmb following cerebral infrc affecting unsp side
I69351	Hemiplga following cerebral infrc aff right dominant side
I69352	Hemiplga following cerebral infrc aff left dominant side
I69353	Hemiplga following cerebral infrc aff right nondom side
I69354	Hemiplga following cerebral infrc affecting left nondom side
I69359	Hemiplga following cerebral infarction affecting unsp side
I69361	Oth parlyt syndrome fol cereb infrc aff right dominant side
I69362	Oth parlyt syndrome fol cereb infrc aff left dominant side
I69363	Oth parlyt syndrome fol cerebral infrc aff right nondom side
I69364	Oth parlyt syndrome fol cerebral infrc aff left nondom side
I69365	Oth paralytic syndrome following cerebral infrc, bilateral

ICD-10-CM Code	Description
I69369	Oth paralytic syndrome fol cerebral infrc aff unsp side
I69390	Apraxia following cerebral infarction
I69391	Dysphagia following cerebral infarction
I69392	Facial weakness following cerebral infarction
I69393	Ataxia following cerebral infarction
I69398	Other sequelae of cerebral infarction
I6980	Unspecified sequelae of other cerebrovascular disease
I6981	Cognitive deficits following other cerebrovascular disease
I69810	Attn and concentration deficit fol other cerebvasc disease
I69811	Memory deficit following other cerebrovascular disease
I69812	Vis def/sptl nglct following other cerebrovascular disease
I69813	Psychomotor deficit following other cerebrovascular disease
I69814	Fntl lb and exec fcn def following other cerebvasc disease
I69815	Cognitive social or emo def fol other cerebvasc disease
I69818	Other symp and signs w cogn fnctns fol other cerebvasc dis
I69819	Unsp symp and signs w cogn fnctns fol other cerebvasc dis
I69820	Aphasia following other cerebrovascular disease
I69821	Dysphasia following other cerebrovascular disease
I69822	Dysarthria following other cerebrovascular disease
I69823	Fluency disorder following other cerebrovascular disease
I69828	Oth speech/lang deficits following oth cerebvasc disease
I69831	Monoplg upr lmb fol oth cerebvasc disease aff right dom side
I69832	Monoplg upr lmb fol oth cerebvasc disease aff left dom side
I69833	Monoplg upr lmb fol oth cerebvasc dis aff right nondom side
I69834	Monoplg upr lmb fol oth cerebvasc dis aff left nondom side
I69839	Monoplg upr lmb fol oth cerebvasc disease aff unsp side
I69841	Monoplg low lmb fol oth cerebvasc disease aff right dom side
I69842	Monoplg low lmb fol oth cerebvasc disease aff left dom side
I69843	Monoplg low lmb fol oth cerebvasc dis aff right nondom side
I69844	Monoplg low lmb fol oth cerebvasc dis aff left nondom side
I69849	Monoplg low lmb fol oth cerebvasc disease aff unsp side
I69851	Hemiplga fol oth cerebvasc disease aff right dominant side
I69852	Hemiplga fol oth cerebvasc disease aff left dominant side
I69853	Hemiplga fol oth cerebvasc disease aff right nondom side
I69854	Hemiplga fol oth cerebvasc disease aff left nondom side
I69859	Hemiplga following oth cerebvasc disease affecting unsp side
I69861	Oth parlyt synd fol oth cerebvasc disease aff right dom side
I69862	Oth parlyt synd fol oth cerebvasc disease aff left dom side
I69863	Oth parlyt synd fol oth cerebvasc dis aff right nondom side
I69864	Oth parlyt synd fol oth cerebvasc dis aff left nondom side

ICD-10-CM Code	Description
I69865	Oth paralytic syndrome following oth cerebvasc disease, bi
I69869	Oth parlyt syndrome fol oth cerebvasc disease aff unsp side
I69890	Apraxia following other cerebrovascular disease
I69891	Dysphagia following other cerebrovascular disease
I69892	Facial weakness following other cerebrovascular disease
I69893	Ataxia following other cerebrovascular disease
I69898	Other sequelae of other cerebrovascular disease
I6990	Unspecified sequelae of unspecified cerebrovascular disease
I6991	Cognitive deficits following unsp cerebrovascular disease
I69910	Attn and concentration deficit fol unsp cerebvasc disease
I69911	Memory deficit following unspecified cerebrovascular disease
I69912	Vis def/sptl nglct following unspecified cerebvasc disease
I69913	Psychomotor deficit following unspecified cerebvasc disease
I69914	Fntl lb and exec fcn def following unsp cerebvasc disease
I69915	Cognitive social or emo def following unsp cerebvasc disease
I69918	Other symp and signs w cogn fnctns fol unsp cerebvasc dis
I69919	Unsp symp and signs w cogn fnctns fol unsp cerebvasc disease
I69920	Aphasia following unspecified cerebrovascular disease
I69921	Dysphasia following unspecified cerebrovascular disease
I69922	Dysarthria following unspecified cerebrovascular disease
I69923	Fluency disorder following unsp cerebrovascular disease
I69928	Oth speech/lang deficits following unsp cerebvasc disease
I69931	Monoplg upr lmb fol unsp cerebvasc dis aff right dom side
I69932	Monoplg upr lmb fol unsp cerebvasc disease aff left dom side
I69933	Monoplg upr lmb fol unsp cerebvasc dis aff right nondom side
I69934	Monoplg upr lmb fol unsp cerebvasc dis aff left nondom side
I69939	Monoplg upr lmb fol unsp cerebvasc disease aff unsp side
I69941	Monoplg low lmb fol unsp cerebvasc dis aff right dom side
I69942	Monoplg low lmb fol unsp cerebvasc disease aff left dom side
I69943	Monoplg low lmb fol unsp cerebvasc dis aff right nondom side
I69944	Monoplg low lmb fol unsp cerebvasc dis aff left nondom side
I69949	Monoplg low lmb fol unsp cerebvasc disease aff unsp side
I69951	Hemiplga fol unsp cerebvasc disease aff right dominant side
I69952	Hemiplga fol unsp cerebvasc disease aff left dominant side
I69953	Hemiplga fol unsp cerebvasc disease aff right nondom side
I69954	Hemiplga fol unsp cerebvasc disease aff left nondom side
I69959	Hemiplga following unsp cerebvasc disease aff unsp side
I69961	Oth parlyt synd fol unsp cerebvasc dis aff right dom side
I69962	Oth parlyt synd fol unsp cerebvasc disease aff left dom side
I69963	Oth parlyt synd fol unsp cerebvasc dis aff right nondom side

ICD-10-CM Code	Description
I69964	Oth parlyt synd fol unsp cerebvasc dis aff left nondom side
I69965	Oth paralytic syndrome following unsp cerebvasc disease, bi
I69969	Oth parlyt syndrome fol unsp cerebvasc disease aff unsp side
I69990	Apraxia following unspecified cerebrovascular disease
I69991	Dysphagia following unspecified cerebrovascular disease
I69992	Facial weakness following unsp cerebrovascular disease
I69993	Ataxia following unspecified cerebrovascular disease
I69998	Other sequelae following unspecified cerebrovascular disease
J1081	Influenza due to oth ident influenza virus w encephalopathy
J1181	Flu due to unidentified influenza virus w encephalopathy
K7682	Hepatic encephalopathy
P9160	Hypoxic ischemic encephalopathy [HIE], unspecified
P9161	Mild hypoxic ischemic encephalopathy [HIE]
P9162	Moderate hypoxic ischemic encephalopathy [HIE]
P9163	Severe hypoxic ischemic encephalopathy [HIE]
S020XXA	Fracture of vault of skull, init encntr for closed fracture
S020XXB	Fracture of vault of skull, init encntr for open fracture
S020XXD	Fracture of vault of skull, subs for fx w routn heal
S020XXG	Fracture of vault of skull, subs for fx w delay heal
S020XXK	Fracture of vault of skull, subs for fx w nonunion
S020XXS	Fracture of vault of skull, sequela
S02101A	Fracture of base of skull, right side, init
S02101B	Fracture of base of skull, right side, 7thB
S02101D	Fracture of base of skull, right side, 7thD
S02101G	Fracture of base of skull, right side, 7thG
S02101K	Fracture of base of skull, right side, 7thK
S02101S	Fracture of base of skull, right side, sequela
S02102A	Fracture of base of skull, left side, init
S02102B	Fracture of base of skull, left side, 7thB
S02102D	Fracture of base of skull, left side, 7thD
S02102G	Fracture of base of skull, left side, 7thG
S02102K	Fracture of base of skull, left side, 7thK
S02102S	Fracture of base of skull, left side, sequela
S02109A	Fracture of base of skull, unspecified side, init
S02109B	Fracture of base of skull, unspecified side, 7thB
S02109D	Fracture of base of skull, unspecified side, 7thD
S02109G	Fracture of base of skull, unspecified side, 7thG
S02109K	Fracture of base of skull, unspecified side, 7thK
S02109S	Fracture of base of skull, unspecified side, sequela
S0210XA	Unsp fracture of base of skull, init for clos fx

ICD-10-CM Code	Description
S0210XB	Unsp fracture of base of skull, init for opn fx
S0210XD	Unsp fracture of base of skull, subs for fx w routn heal
S0210XG	Unsp fracture of base of skull, subs for fx w delay heal
S0210XK	Unsp fracture of base of skull, subs for fx w nonunion
S0210XS	Unspecified fracture of base of skull, sequela
S02110A	Type I occipital condyle fracture, unsp side, init for clos fx
S02110B	Type I occipital condyle fracture, unsp side, init for opn fx
S02110D	Type I occipital condyle fracture, unsp side, subs for fx w routn heal
S02110G	Type I occipital condyle fracture, unsp side, subs for fx w delay heal
S02110K	Type I occipital condyle fracture, unsp side, subs for fx w nonunion
S02110S	Type I occipital condyle fracture, unsp side, sequela
S02111A	Type II occipital condyle fracture, unsp side, init for clos fx
S02111B	Type II occipital condyle fracture, unsp side, init for opn fx
S02111D	Type II occipital condyle fracture, unsp side, subs for fx w routn heal
S02111G	Type II occipital condyle fracture, unsp side, subs for fx w delay heal
S02111K	Type II occipital condyle fracture, unsp side, subs for fx w nonunion
S02111S	Type II occipital condyle fracture, unsp side, sequela
S02112A	Type III occipital condyle fracture, unsp side, init for clos fx
S02112B	Type III occipital condyle fracture, unsp side, init for opn fx
S02112D	Type III occipital condyle fx, unsp side, subs for fx w routn heal
S02112G	Type III occipital condyle fx, unsp side, subs for fx w delay heal
S02112K	Type III occipital condyle fracture, unsp side, subs for fx w nonunion
S02112S	Type III occipital condyle fracture, unsp side, sequela
S02113A	Unsp occipital condyle fracture, init for clos fx
S02113B	Unsp occipital condyle fracture, init for opn fx
S02113D	Unsp occipital condyle fracture, subs for fx w routn heal
S02113G	Unsp occipital condyle fracture, subs for fx w delay heal
S02113K	Unsp occipital condyle fracture, subs for fx w nonunion
S02113S	Unspecified occipital condyle fracture, sequela
S02118A	Other fracture of occiput, unsp side, init encntr for closed fracture
S02118B	Other fracture of occiput,unsp side, init encntr for open fracture
S02118D	Oth fracture of occiput, unsp side, subs for fx w routn heal
S02118G	Oth fracture of occiput, unsp side, subs for fx w delay heal
S02118K	Oth fracture of occiput, unsp side, subs encntr for fracture w nonunion
S02118S	Other fracture of occiput, unsp side, sequela

ICD-10-CM Code	Description
S02119A	Unsp fracture of occiput, init encntr for closed fracture
S02119B	Unsp fracture of occiput, init encntr for open fracture
S02119D	Unsp fracture of occiput, subs for fx w routn heal
S02119G	Unsp fracture of occiput, subs for fx w delay heal
S02119K	Unsp fracture of occiput, subs for fx w nonunion
S02119S	Unspecified fracture of occiput, sequela
S0211AA	Type I occipital condyle fracture, right side, init
S0211AB	Type I occipital condyle fracture, right side, 7thB
S0211AD	Type I occipital condyle fracture, right side, 7thD
S0211AG	Type I occipital condyle fracture, right side, 7thG
S0211AK	Type I occipital condyle fracture, right side, 7thK
S0211AS	Type I occipital condyle fracture, right side, sequela
S0211BA	Type I occipital condyle fracture, left side, init
S0211BB	Type I occipital condyle fracture, left side, 7thB
S0211BD	Type I occipital condyle fracture, left side, 7thD
S0211BG	Type I occipital condyle fracture, left side, 7thG
S0211BK	Type I occipital condyle fracture, left side, 7thK
S0211BS	Type I occipital condyle fracture, left side, sequela
S0211CA	Type II occipital condyle fracture, right side, init
S0211CB	Type II occipital condyle fracture, right side, 7thB
S0211CD	Type II occipital condyle fracture, right side, 7thD
S0211CG	Type II occipital condyle fracture, right side, 7thG
S0211CK	Type II occipital condyle fracture, right side, 7thK
S0211CS	Type II occipital condyle fracture, right side, sequela
S0211DA	Type II occipital condyle fracture, left side, init
S0211DB	Type II occipital condyle fracture, left side, 7thB
S0211DD	Type II occipital condyle fracture, left side, 7thD
S0211DG	Type II occipital condyle fracture, left side, 7thG
S0211DK	Type II occipital condyle fracture, left side, 7thK
S0211DS	Type II occipital condyle fracture, left side, sequela
S0211EA	Type III occipital condyle fracture, right side, init
S0211EB	Type III occipital condyle fracture, right side, 7thB
S0211ED	Type III occipital condyle fracture, right side, 7thD
S0211EG	Type III occipital condyle fracture, right side, 7thG
S0211EK	Type III occipital condyle fracture, right side, 7thK
S0211ES	Type III occipital condyle fracture, right side, sequela
S0211FA	Type III occipital condyle fracture, left side, init
S0211FB	Type III occipital condyle fracture, left side, 7thB
S0211FD	Type III occipital condyle fracture, left side, 7thD
S0211FG	Type III occipital condyle fracture, left side, 7thG

ICD-10-CM Code	Description
S0211FK	Type III occipital condyle fracture, left side, 7thK
S0211FS	Type III occipital condyle fracture, left side, sequela
S0211GA	Other fracture of occiput, right side, init
S0211GB	Other fracture of occiput, right side, 7thB
S0211GD	Other fracture of occiput, right side, 7thD
S0211GG	Other fracture of occiput, right side, 7thG
S0211GK	Other fracture of occiput, right side, 7thK
S0211GS	Other fracture of occiput, right side, sequela
S0211HA	Other fracture of occiput, left side, init
S0211HB	Other fracture of occiput, left side, 7thB
S0211HD	Other fracture of occiput, left side, 7thD
S0211HG	Other fracture of occiput, left side, 7thG
S0211HK	Other fracture of occiput, left side, 7thK
S0211HS	Other fracture of occiput, left side, sequela
S02121A	Fracture of orbital roof, right side, init
S02121B	Fracture of orbital roof, right side, 7thB
S02121D	Fracture of orbital roof, right side, 7thD
S02121G	Fracture of orbital roof, right side, 7thG
S02121K	Fracture of orbital roof, right side, 7thK
S02121S	Fracture of orbital roof, right side, sequela
S02122A	Fracture of orbital roof, left side, init
S02122B	Fracture of orbital roof, left side, 7thB
S02122D	Fracture of orbital roof, left side, 7thD
S02122G	Fracture of orbital roof, left side, 7thG
S02122K	Fracture of orbital roof, left side, 7thK
S02122S	Fracture of orbital roof, left side, sequela
S02129A	Fracture of orbital roof, unspecified side, init
S02129B	Fracture of orbital roof, unspecified side, 7thB
S02129D	Fracture of orbital roof, unspecified side, 7thD
S02129G	Fracture of orbital roof, unspecified side, 7thG
S02129K	Fracture of orbital roof, unspecified side, 7thK
S02129S	Fracture of orbital roof, unspecified side, sequela
S0219XA	Oth fracture of base of skull, init for clos fx
S0219XB	Oth fracture of base of skull, init encntr for open fracture
S0219XD	Oth fracture of base of skull, subs for fx w routn heal
S0219XG	Oth fracture of base of skull, subs for fx w delay heal
S0219XK	Oth fracture of base of skull, subs for fx w nonunion
S0219XS	Other fracture of base of skull, sequela
S0280XA	Fx oth skull and facial bones, unspecified side, init
S0280XB	Fx oth skull and facial bones, unspecified side, 7thB

ICD-10-CM Code	Description
S0280XD	Fx oth skull and facial bones, unspecified side, 7thD
S0280XG	Fx oth skull and facial bones, unspecified side, 7thG
S0280XK	Fx oth skull and facial bones, unspecified side, 7thK
S0280XS	Fx oth skull and facial bones, unspecified side, sequela
S0281XA	Fracture of oth skull and facial bones, right side, init
S0281XB	Fracture of oth skull and facial bones, right side, 7thB
S0281XD	Fracture of oth skull and facial bones, right side, 7thD
S0281XG	Fracture of oth skull and facial bones, right side, 7thG
S0281XK	Fracture of oth skull and facial bones, right side, 7thK
S0281XS	Fracture of oth skull and facial bones, right side, sequela
S0282XA	Fracture of oth skull and facial bones, left side, init
S0282XB	Fracture of oth skull and facial bones, left side, 7thB
S0282XD	Fracture of oth skull and facial bones, left side, 7thD
S0282XG	Fracture of oth skull and facial bones, left side, 7thG
S0282XK	Fracture of oth skull and facial bones, left side, 7thK
S0282XS	Fracture of oth skull and facial bones, left side, sequela
S060X0A	Concussion without loss of consciousness, initial encounter
S060X0D	Concussion without loss of consciousness, subs encntr
S060X0S	Concussion without loss of consciousness, sequela
S060X1A	Concussion w LOC of 30 minutes or less, init
S060X1D	Concussion w LOC of 30 minutes or less, subs
S060X1S	Concussion w LOC of 30 minutes or less, sequela
S060X2A	Concussion w loss of consciousness of 31-59 min, init
S060X2D	Concussion w loss of consciousness of 31-59 min, subs
S060X2S	Concussion w loss of consciousness of 31-59 min, sequela
S060X3A	Concussion w loss of consciousness of 1-5 hrs 59 min, init
S060X3D	Concussion w loss of consciousness of 1-5 hrs 59 min, subs
S060X3S	Concussion w LOC of 1-5 hrs 59 min, sequela
S060X4A	Concussion w LOC of 6 hours to 24 hours, init
S060X4D	Concussion w LOC of 6 hours to 24 hours, subs
S060X4S	Concussion w LOC of 6 hours to 24 hours, sequela
S060X5A	Concussion w LOC >24 hr w ret consc lev, init
S060X5D	Concussion w LOC >24 hr w ret consc lev, subs
S060X5S	Concussion w LOC >24 hr w ret consc lev, sequela
S060X6A	Concussion w LOC >24 hr w/o ret consc w surv, init
S060X6D	Concussion w LOC >24 hr w/o ret consc w surv, subs
S060X6S	Concussion w LOC >24 hr w/o ret consc w surv, sequela
S060X9A	Concussion w loss of consciousness of unsp duration, init
S060X9D	Concussion w loss of consciousness of unsp duration, subs
S060X9S	Concussion w loss of consciousness of unsp duration, sequela

ICD-10-CM Code	Description
S060XAA	Concussion with LOC status unknown, initial encounter
S060XAD	Concussion with LOC status unknown, subsequent encounter
S060XAS	Concussion with LOC status unknown, sequela
S061X0A	Traumatic cerebral edema w/o loss of consciousness, init
S061X0D	Traumatic cerebral edema w/o loss of consciousness, subs
S061X0S	Traumatic cerebral edema w/o loss of consciousness, sequela
S061X1A	Traumatic cerebral edema w LOC of 30 minutes or less, init
S061X1D	Traumatic cerebral edema w LOC of 30 minutes or less, subs
S061X1S	Traum cerebral edema w LOC of 30 minutes or less, sequela
S061X2A	Traumatic cerebral edema w LOC of 31-59 min, init
S061X2D	Traumatic cerebral edema w LOC of 31-59 min, subs
S061X2S	Traumatic cerebral edema w LOC of 31-59 min, sequela
S061X3A	Traumatic cerebral edema w LOC of 1-5 hrs 59 min, init
S061X3D	Traumatic cerebral edema w LOC of 1-5 hrs 59 min, subs
S061X3S	Traumatic cerebral edema w LOC of 1-5 hrs 59 min, sequela
S061X4A	Traumatic cerebral edema w LOC of 6 hours to 24 hours, init
S061X4D	Traumatic cerebral edema w LOC of 6 hours to 24 hours, subs
S061X4S	Traumatic cerebral edema w LOC of 6-24 hrs, sequela
S061X5A	Traumatic cerebral edema w LOC >24 hr w ret consc lev, init
S061X5D	Traumatic cerebral edema w LOC >24 hr w ret consc lev, subs
S061X5S	Traum cerebral edema w LOC >24 hr w ret consc lev, sequela
S061X6A	Traum cerebral edema w LOC >24 hr w/o ret consc w surv, init
S061X6D	Traum cerebral edema w LOC >24 hr w/o ret consc w surv, subs
S061X6S	Traum cereb edema w LOC >24 hr w/o ret consc w surv, sequela
S061X9A	Traumatic cerebral edema w LOC of unsp duration, init
S061X9D	Traumatic cerebral edema w LOC of unsp duration, subs
S061X9S	Traumatic cerebral edema w LOC of unsp duration, sequela
S061XAA	Traumatic cerebral edema with LOC status unknown, init
S061XAD	Traumatic cerebral edema with LOC status unknown, subs
S061XAS	Traumatic cerebral edema with LOC status unknown, sequela
S062X0A	Diffuse TBI w/o loss of consciousness, init
S062X0D	Diffuse TBI w/o loss of consciousness, subs
S062X0S	Diffuse TBI w/o loss of consciousness, sequela
S062X1A	Diffuse TBI w LOC of 30 minutes or less, init
S062X1D	Diffuse TBI w LOC of 30 minutes or less, subs
S062X1S	Diffuse TBI w LOC of 30 minutes or less, sequela
S062X2A	Diffuse TBI w loss of consciousness of 31-59 min, init
S062X2D	Diffuse TBI w loss of consciousness of 31-59 min, subs
S062X2S	Diffuse TBI w loss of consciousness of 31-59 min, sequela
S062X3A	Diffuse TBI w loss of consciousness of 1-5 hrs 59 min, init

ICD-10-CM Code	Description
S062X3D	Diffuse TBI w loss of consciousness of 1-5 hrs 59 min, subs
S062X3S	Diffuse TBI w LOC of 1-5 hrs 59 min, sequela
S062X4A	Diffuse TBI w LOC of 6 hours to 24 hours, init
S062X4D	Diffuse TBI w LOC of 6 hours to 24 hours, subs
S062X4S	Diffuse TBI w LOC of 6 hours to 24 hours, sequela
S062X5A	Diffuse TBI w LOC >24 hr w return to conscious levels, init
S062X5D	Diffuse TBI w LOC >24 hr w return to conscious levels, subs
S062X5S	Diffuse TBI w LOC >24 hr w return to consc levels, sequela
S062X6A	Diffuse TBI w LOC >24 hr w/o ret consc w surv, init
S062X6D	Diffuse TBI w LOC >24 hr w/o ret consc w surv, subs
S062X6S	Diffuse TBI w LOC >24 hr w/o ret consc w surv, sequela
S062X9A	Diffuse TBI w loss of consciousness of unsp duration, init
S062X9D	Diffuse TBI w loss of consciousness of unsp duration, subs
S062X9S	Diffuse TBI w LOC of unsp duration, sequela
S062XAA	Diffuse TBI with LOC status unknown, initial encounter
S062XAD	Diffuse TBI with LOC status unknown, subsequent encounter
S062XAS	Diffuse TBI with LOC status unknown, sequela
S06300A	Unsp focal TBI w/o loss of consciousness, init
S06300D	Unsp focal TBI w/o loss of consciousness, subs
S06300S	Unsp focal TBI w/o loss of consciousness, sequela
S06301A	Unsp focal TBI w LOC of 30 minutes or less, init
S06301D	Unsp focal TBI w LOC of 30 minutes or less, subs
S06301S	Unsp focal TBI w LOC of 30 minutes or less, sequela
S06302A	Unsp focal TBI w loss of consciousness of 31-59 min, init
S06302D	Unsp focal TBI w loss of consciousness of 31-59 min, subs
S06302S	Unsp focal TBI w loss of consciousness of 31-59 min, sequela
S06303A	Unsp focal TBI w LOC of 1-5 hrs 59 min, init
S06303D	Unsp focal TBI w LOC of 1-5 hrs 59 min, subs
S06303S	Unsp focal TBI w LOC of 1-5 hrs 59 min, sequela
S06304A	Unsp focal TBI w LOC of 6 hours to 24 hours, init
S06304D	Unsp focal TBI w LOC of 6 hours to 24 hours, subs
S06304S	Unsp focal TBI w LOC of 6 hours to 24 hours, sequela
S06305A	Unsp focal TBI w LOC >24 hr w ret consc lev, init
S06305D	Unsp focal TBI w LOC >24 hr w ret consc lev, subs
S06305S	Unsp focal TBI w LOC >24 hr w ret consc lev, sequela
S06306A	Unsp focal TBI w LOC >24 hr w/o ret consc w surv, init
S06306D	Unsp focal TBI w LOC >24 hr w/o ret consc w surv, subs
S06306S	Unsp focal TBI w LOC >24 hr w/o ret consc w surv, sequela
S06309A	Unsp focal TBI w LOC of unsp duration, init
S06309D	Unsp focal TBI w LOC of unsp duration, subs

ICD-10-CM Code	Description
S06309S	Unsp focal TBI w LOC of unsp duration, sequela
S0630AA	Unspecified focal TBI with LOC status unknown, init
S0630AD	Unspecified focal TBI with LOC status unknown, subs
S0630AS	Unspecified focal TBI with LOC status unknown, sequela
S06310A	Contus/lac right cerebrum w/o loss of consciousness, init
S06310D	Contus/lac right cerebrum w/o loss of consciousness, subs
S06310S	Contus/lac right cerebrum w/o loss of consciousness, sequela
S06311A	Contus/lac right cerebrum w LOC of 30 minutes or less, init
S06311D	Contus/lac right cerebrum w LOC of 30 minutes or less, subs
S06311S	Contus/lac r cereb w LOC of 30 minutes or less, sequela
S06312A	Contus/lac right cerebrum w LOC of 31-59 min, init
S06312D	Contus/lac right cerebrum w LOC of 31-59 min, subs
S06312S	Contus/lac right cerebrum w LOC of 31-59 min, sequela
S06313A	Contus/lac right cerebrum w LOC of 1-5 hrs 59 min, init
S06313D	Contus/lac right cerebrum w LOC of 1-5 hrs 59 min, subs
S06313S	Contus/lac right cerebrum w LOC of 1-5 hrs 59 min, sequela
S06314A	Contus/lac right cerebrum w LOC of 6 hours to 24 hours, init
S06314D	Contus/lac right cerebrum w LOC of 6 hours to 24 hours, subs
S06314S	Contus/lac right cerebrum w LOC of 6-24 hrs, sequela
S06315A	Contus/lac right cerebrum w LOC >24 hr w ret consc lev, init
S06315D	Contus/lac right cerebrum w LOC >24 hr w ret consc lev, subs
S06315S	Contus/lac r cereb w LOC >24 hr w ret consc lev, sequela
S06316A	Contus/lac r cereb w LOC >24 hr w/o ret consc w surv, init
S06316D	Contus/lac r cereb w LOC >24 hr w/o ret consc w surv, subs
S06316S	Contus/lac r cereb w LOC >24 hr w/o ret consc w surv, sqla
S06319A	Contus/lac right cerebrum w LOC of unsp duration, init
S06319D	Contus/lac right cerebrum w LOC of unsp duration, subs
S06319S	Contus/lac right cerebrum w LOC of unsp duration, sequela
S0631AA	Contus/lac right cerebrum with LOC status unknown, init
S0631AD	Contus/lac right cerebrum with LOC status unknown, subs
S0631AS	Contus/lac right cerebrum with LOC status unknown, sequela
S06320A	Contus/lac left cerebrum w/o loss of consciousness, init
S06320D	Contus/lac left cerebrum w/o loss of consciousness, subs
S06320S	Contus/lac left cerebrum w/o loss of consciousness, sequela
S06321A	Contus/lac left cerebrum w LOC of 30 minutes or less, init
S06321D	Contus/lac left cerebrum w LOC of 30 minutes or less, subs
S06321S	Contus/lac l cereb w LOC of 30 minutes or less, sequela
S06322A	Contus/lac left cerebrum w LOC of 31-59 min, init
S06322D	Contus/lac left cerebrum w LOC of 31-59 min, subs
S06322S	Contus/lac left cerebrum w LOC of 31-59 min, sequela

ICD-10-CM Code	Description
S06323A	Contus/lac left cerebrum w LOC of 1-5 hrs 59 min, init
S06323D	Contus/lac left cerebrum w LOC of 1-5 hrs 59 min, subs
S06323S	Contus/lac left cerebrum w LOC of 1-5 hrs 59 min, sequela
S06324A	Contus/lac left cerebrum w LOC of 6 hours to 24 hours, init
S06324D	Contus/lac left cerebrum w LOC of 6 hours to 24 hours, subs
S06324S	Contus/lac left cerebrum w LOC of 6-24 hrs, sequela
S06325A	Contus/lac left cerebrum w LOC >24 hr w ret consc lev, init
S06325D	Contus/lac left cerebrum w LOC >24 hr w ret consc lev, subs
S06325S	Contus/lac l cereb w LOC >24 hr w ret consc lev, sequela
S06326A	Contus/lac l cereb w LOC >24 hr w/o ret consc w surv, init
S06326D	Contus/lac l cereb w LOC >24 hr w/o ret consc w surv, subs
S06326S	Contus/lac l cereb w LOC >24 hr w/o ret consc w surv, sqla
S06329A	Contus/lac left cerebrum w LOC of unsp duration, init
S06329D	Contus/lac left cerebrum w LOC of unsp duration, subs
S06329S	Contus/lac left cerebrum w LOC of unsp duration, sequela
S0632AA	Contus/lac left cerebrum with LOC status unknown, init
S0632AD	Contus/lac left cerebrum with LOC status unknown, subs
S0632AS	Contus/lac left cerebrum with LOC status unknown, sequela
S06330A	Contus/lac cereb, w/o loss of consciousness, init
S06330D	Contus/lac cereb, w/o loss of consciousness, subs
S06330S	Contus/lac cereb, w/o loss of consciousness, sequela
S06331A	Contus/lac cereb, w LOC of 30 minutes or less, init
S06331D	Contus/lac cereb, w LOC of 30 minutes or less, subs
S06331S	Contus/lac cereb, w LOC of 30 minutes or less, sequela
S06332A	Contus/lac cereb, w loss of consciousness of 31-59 min, init
S06332D	Contus/lac cereb, w loss of consciousness of 31-59 min, subs
S06332S	Contus/lac cereb, w LOC of 31-59 min, sequela
S06333A	Contus/lac cereb, w LOC of 1-5 hrs 59 min, init
S06333D	Contus/lac cereb, w LOC of 1-5 hrs 59 min, subs
S06333S	Contus/lac cereb, w LOC of 1-5 hrs 59 min, sequela
S06334A	Contus/lac cereb, w LOC of 6 hours to 24 hours, init
S06334D	Contus/lac cereb, w LOC of 6 hours to 24 hours, subs
S06334S	Contus/lac cereb, w LOC of 6 hours to 24 hours, sequela
S06335A	Contus/lac cereb, w LOC >24 hr w ret consc lev, init
S06335D	Contus/lac cereb, w LOC >24 hr w ret consc lev, subs
S06335S	Contus/lac cereb, w LOC >24 hr w ret consc lev, sequela
S06336A	Contus/lac cereb, w LOC >24 hr w/o ret consc w surv, init
S06336D	Contus/lac cereb, w LOC >24 hr w/o ret consc w surv, subs
S06336S	Contus/lac cereb, w LOC >24 hr w/o ret consc w surv, sequela
S06339A	Contus/lac cereb, w LOC of unsp duration, init

ICD-10-CM Code	Description
S06339D	Contus/lac cereb, w LOC of unsp duration, subs
S06339S	Contus/lac cereb, w LOC of unsp duration, sequela
S0633AA	Contus/lac cereb, with LOC status unknown, initial encounter
S0633AD	Contus/lac cereb, with LOC status unknown, subs
S0633AS	Contus/lac cereb, with LOC status unknown, sequela
S06340A	Traum hemor right cerebrum w/o loss of consciousness, init
S06340D	Traum hemor right cerebrum w/o loss of consciousness, subs
S06340S	Traum hemor right cerebrum w/o LOC, sequela
S06341A	Traum hemor right cerebrum w LOC of 30 minutes or less, init
S06341D	Traum hemor right cerebrum w LOC of 30 minutes or less, subs
S06341S	Traum hemor r cereb w LOC of 30 minutes or less, sequela
S06342A	Traum hemor right cerebrum w LOC of 31-59 min, init
S06342D	Traum hemor right cerebrum w LOC of 31-59 min, subs
S06342S	Traum hemor right cerebrum w LOC of 31-59 min, sequela
S06343A	Traum hemor right cerebrum w LOC of 1-5 hrs 59 minutes, init
S06343D	Traum hemor right cerebrum w LOC of 1-5 hrs 59 minutes, subs
S06343S	Traum hemor r cereb w LOC of 1-5 hrs 59 minutes, sequela
S06344A	Traum hemor right cerebrum w LOC of 6-24 hrs, init
S06344D	Traum hemor right cerebrum w LOC of 6-24 hrs, subs
S06344S	Traum hemor right cerebrum w LOC of 6-24 hrs, sequela
S06345A	Traum hemor r cereb w LOC >24 hr w ret consc lev, init
S06345D	Traum hemor r cereb w LOC >24 hr w ret consc lev, subs
S06345S	Traum hemor r cereb w LOC >24 hr w ret consc lev, sequela
S06346A	Traum hemor r cereb w LOC >24 hr w/o ret consc w surv, init
S06346D	Traum hemor r cereb w LOC >24 hr w/o ret consc w surv, subs
S06346S	Traum hemor r cereb w LOC >24 hr w/o ret consc w surv, sqla
S06349A	Traum hemor right cerebrum w LOC of unsp duration, init
S06349D	Traum hemor right cerebrum w LOC of unsp duration, subs
S06349S	Traum hemor right cerebrum w LOC of unsp duration, sequela
S0634AA	Traum hemor right cerebrum with LOC status unknown, init
S0634AD	Traum hemor right cerebrum with LOC status unknown, subs
S0634AS	Traum hemor right cerebrum with LOC status unknown, sequela
S06350A	Traum hemor left cerebrum w/o loss of consciousness, init
S06350D	Traum hemor left cerebrum w/o loss of consciousness, subs
S06350S	Traum hemor left cerebrum w/o loss of consciousness, sequela
S06351A	Traum hemor left cerebrum w LOC of 30 minutes or less, init
S06351D	Traum hemor left cerebrum w LOC of 30 minutes or less, subs
S06351S	Traum hemor l cereb w LOC of 30 minutes or less, sequela
S06352A	Traum hemor left cerebrum w LOC of 31-59 min, init
S06352D	Traum hemor left cerebrum w LOC of 31-59 min, subs

ICD-10-CM Code	Description
S06352S	Traum hemor left cerebrum w LOC of 31-59 min, sequela
S06353A	Traum hemor left cerebrum w LOC of 1-5 hrs 59 minutes, init
S06353D	Traum hemor left cerebrum w LOC of 1-5 hrs 59 minutes, subs
S06353S	Traum hemor l cereb w LOC of 1-5 hrs 59 minutes, sequela
S06354A	Traum hemor left cerebrum w LOC of 6 hours to 24 hours, init
S06354D	Traum hemor left cerebrum w LOC of 6 hours to 24 hours, subs
S06354S	Traum hemor left cerebrum w LOC of 6-24 hrs, sequela
S06355A	Traum hemor left cerebrum w LOC >24 hr w ret consc lev, init
S06355D	Traum hemor left cerebrum w LOC >24 hr w ret consc lev, subs
S06355S	Traum hemor l cereb w LOC >24 hr w ret consc lev, sequela
S06356A	Traum hemor l cereb w LOC >24 hr w/o ret consc w surv, init
S06356D	Traum hemor l cereb w LOC >24 hr w/o ret consc w surv, subs
S06356S	Traum hemor l cereb w LOC >24 hr w/o ret consc w surv, sqla
S06359A	Traum hemor left cerebrum w LOC of unsp duration, init
S06359D	Traum hemor left cerebrum w LOC of unsp duration, subs
S06359S	Traum hemor left cerebrum w LOC of unsp duration, sequela
S0635AA	Traum hemor left cerebrum with LOC status unknown, init
S0635AD	Traum hemor left cerebrum with LOC status unknown, subs
S0635AS	Traum hemor left cerebrum with LOC status unknown, sequela
S06360A	Traum hemor cereb, w/o loss of consciousness, init
S06360D	Traum hemor cereb, w/o loss of consciousness, subs
S06360S	Traum hemor cereb, w/o loss of consciousness, sequela
S06361A	Traum hemor cereb, w LOC of 30 minutes or less, init
S06361D	Traum hemor cereb, w LOC of 30 minutes or less, subs
S06361S	Traum hemor cereb, w LOC of 30 minutes or less, sequela
S06362A	Traum hemor cereb, w LOC of 31-59 min, init
S06362D	Traum hemor cereb, w LOC of 31-59 min, subs
S06362S	Traum hemor cereb, w LOC of 31-59 min, sequela
S06363A	Traum hemor cereb, w LOC of 1-5 hrs 59 minutes, init
S06363D	Traum hemor cereb, w LOC of 1-5 hrs 59 minutes, subs
S06363S	Traum hemor cereb, w LOC of 1-5 hrs 59 minutes, sequela
S06364A	Traum hemor cereb, w LOC of 6 hours to 24 hours, init
S06364D	Traum hemor cereb, w LOC of 6 hours to 24 hours, subs
S06364S	Traum hemor cereb, w LOC of 6 hours to 24 hours, sequela
S06365A	Traum hemor cereb, w LOC >24 hr w ret consc lev, init
S06365D	Traum hemor cereb, w LOC >24 hr w ret consc lev, subs
S06365S	Traum hemor cereb, w LOC >24 hr w ret consc lev, sequela
S06366A	Traum hemor cereb, w LOC >24 hr w/o ret consc w surv, init
S06366D	Traum hemor cereb, w LOC >24 hr w/o ret consc w surv, subs
S06366S	Traum hemor cereb, w LOC >24 hr w/o ret consc w surv, sqla

ICD-10-CM Code	Description
S06369A	Traum hemor cereb, w LOC of unsp duration, init
S06369D	Traum hemor cereb, w LOC of unsp duration, subs
S06369S	Traum hemor cereb, w LOC of unsp duration, sequela
S0636AA	Traum hemor cereb, with LOC status unknown, init
S0636AD	Traum hemor cereb, with LOC status unknown, subs
S0636AS	Traum hemor cereb, with LOC status unknown, sequela
S06370A	Contus/lac/hem crblm w/o loss of consciousness, init
S06370D	Contus/lac/hem crblm w/o loss of consciousness, subs
S06370S	Contus/lac/hem crblm w/o loss of consciousness, sequela
S06371A	Contus/lac/hem crblm w LOC of 30 minutes or less, init
S06371D	Contus/lac/hem crblm w LOC of 30 minutes or less, subs
S06371S	Contus/lac/hem crblm w LOC of 30 minutes or less, sequela
S06372A	Contus/lac/hem crblm w LOC of 31-59 min, init
S06372D	Contus/lac/hem crblm w LOC of 31-59 min, subs
S06372S	Contus/lac/hem crblm w LOC of 31-59 min, sequela
S06373A	Contus/lac/hem crblm w LOC of 1-5 hrs 59 min, init
S06373D	Contus/lac/hem crblm w LOC of 1-5 hrs 59 min, subs
S06373S	Contus/lac/hem crblm w LOC of 1-5 hrs 59 min, sequela
S06374A	Contus/lac/hem crblm w LOC of 6 hours to 24 hours, init
S06374D	Contus/lac/hem crblm w LOC of 6 hours to 24 hours, subs
S06374S	Contus/lac/hem crblm w LOC of 6 hours to 24 hours, sequela
S06375A	Contus/lac/hem crblm w LOC >24 hr w ret consc lev, init
S06375D	Contus/lac/hem crblm w LOC >24 hr w ret consc lev, subs
S06375S	Contus/lac/hem crblm w LOC >24 hr w ret consc lev, sequela
S06376A	Contus/lac/hem crblm w LOC >24 hr w/o ret consc w surv, init
S06376D	Contus/lac/hem crblm w LOC >24 hr w/o ret consc w surv, subs
S06376S	Contus/lac/hem crblm w LOC >24 hr w/o ret consc w surv, sqla
S06379A	Contus/lac/hem crblm w LOC of unsp duration, init
S06379D	Contus/lac/hem crblm w LOC of unsp duration, subs
S06379S	Contus/lac/hem crblm w LOC of unsp duration, sequela
S0637AA	Contus/lac/hem crblm with LOC status unknown, init
S0637AD	Contus/lac/hem crblm with LOC status unknown, subs
S0637AS	Contus/lac/hem crblm with LOC status unknown, sequela
S06380A	Contus/lac/hem brainstem w/o loss of consciousness, init
S06380D	Contus/lac/hem brainstem w/o loss of consciousness, subs
S06380S	Contus/lac/hem brainstem w/o loss of consciousness, sequela
S06381A	Contus/lac/hem brainstem w LOC of 30 minutes or less, init
S06381D	Contus/lac/hem brainstem w LOC of 30 minutes or less, subs
S06381S	Contus/lac/hem brnst w LOC of 30 minutes or less, sequela
S06382A	Contus/lac/hem brainstem w LOC of 31-59 min, init

ICD-10-CM Code	Description
S06382D	Contus/lac/hem brainstem w LOC of 31-59 min, subs
S06382S	Contus/lac/hem brainstem w LOC of 31-59 min, sequela
S06383A	Contus/lac/hem brainstem w LOC of 1-5 hrs 59 min, init
S06383D	Contus/lac/hem brainstem w LOC of 1-5 hrs 59 min, subs
S06383S	Contus/lac/hem brainstem w LOC of 1-5 hrs 59 min, sequela
S06384A	Contus/lac/hem brainstem w LOC of 6 hours to 24 hours, init
S06384D	Contus/lac/hem brainstem w LOC of 6 hours to 24 hours, subs
S06384S	Contus/lac/hem brainstem w LOC of 6-24 hrs, sequela
S06385A	Contus/lac/hem brainstem w LOC >24 hr w ret consc lev, init
S06385D	Contus/lac/hem brainstem w LOC >24 hr w ret consc lev, subs
S06385S	Contus/lac/hem brnst w LOC >24 hr w ret consc lev, sequela
S06386A	Contus/lac/hem brnst w LOC >24 hr w/o ret consc w surv, init
S06386D	Contus/lac/hem brnst w LOC >24 hr w/o ret consc w surv, subs
S06386S	Contus/lac/hem brnst w LOC >24 hr w/o ret consc w surv, sqla
S06389A	Contus/lac/hem brainstem w LOC of unsp duration, init
S06389D	Contus/lac/hem brainstem w LOC of unsp duration, subs
S06389S	Contus/lac/hem brainstem w LOC of unsp duration, sequela
S0638AA	Contus/lac/hem brainstem with LOC status unknown, init
S0638AD	Contus/lac/hem brainstem with LOC status unknown, subs
S0638AS	Contus/lac/hem brainstem with LOC status unknown, sequela
S064X0A	Epidural hemorrhage w/o loss of consciousness, init encntr
S064X0D	Epidural hemorrhage w/o loss of consciousness, subs encntr
S064X0S	Epidural hemorrhage without loss of consciousness, sequela
S064X1A	Epidural hemorrhage w LOC of 30 minutes or less, init
S064X1D	Epidural hemorrhage w LOC of 30 minutes or less, subs
S064X1S	Epidural hemorrhage w LOC of 30 minutes or less, sequela
S064X2A	Epidural hemorrhage w LOC of 31-59 min, init
S064X2D	Epidural hemorrhage w LOC of 31-59 min, subs
S064X2S	Epidural hemorrhage w LOC of 31-59 min, sequela
S064X3A	Epidural hemorrhage w LOC of 1-5 hrs 59 min, init
S064X3D	Epidural hemorrhage w LOC of 1-5 hrs 59 min, subs
S064X3S	Epidural hemorrhage w LOC of 1-5 hrs 59 min, sequela
S064X4A	Epidural hemorrhage w LOC of 6 hours to 24 hours, init
S064X4D	Epidural hemorrhage w LOC of 6 hours to 24 hours, subs
S064X4S	Epidural hemorrhage w LOC of 6 hours to 24 hours, sequela
S064X5A	Epidural hemorrhage w LOC >24 hr w ret consc lev, init
S064X5D	Epidural hemorrhage w LOC >24 hr w ret consc lev, subs
S064X5S	Epidural hemorrhage w LOC >24 hr w ret consc lev, sequela
S064X6A	Epidural hemorrhage w LOC >24 hr w/o ret consc w surv, init
S064X6D	Epidural hemorrhage w LOC >24 hr w/o ret consc w surv, subs

ICD-10-CM Code	Description
S064X6S	Epidural hemor w LOC >24 hr w/o ret consc w surv, sequela
S064X9A	Epidural hemorrhage w LOC of unsp duration, init
S064X9D	Epidural hemorrhage w LOC of unsp duration, subs
S064X9S	Epidural hemorrhage w LOC of unsp duration, sequela
S064XAA	Epidural hemorrhage with LOC status unknown, init
S064XAD	Epidural hemorrhage with LOC status unknown, subs
S064XAS	Epidural hemorrhage with LOC status unknown, sequela
S065X0A	Traum subdr hem w/o loss of consciousness, init
S065X0D	Traum subdr hem w/o loss of consciousness, subs
S065X0S	Traum subdr hem w/o loss of consciousness, sequela
S065X1A	Traum subdr hem w LOC of 30 minutes or less, init
S065X1D	Traum subdr hem w LOC of 30 minutes or less, subs
S065X1S	Traum subdr hem w LOC of 30 minutes or less, sequela
S065X2A	Traum subdr hem w loss of consciousness of 31-59 min, init
S065X2D	Traum subdr hem w loss of consciousness of 31-59 min, subs
S065X2S	Traum subdr hem w LOC of 31-59 min, sequela
S065X3A	Traum subdr hem w LOC of 1-5 hrs 59 min, init
S065X3D	Traum subdr hem w LOC of 1-5 hrs 59 min, subs
S065X3S	Traum subdr hem w LOC of 1-5 hrs 59 min, sequela
S065X4A	Traum subdr hem w LOC of 6 hours to 24 hours, init
S065X4D	Traum subdr hem w LOC of 6 hours to 24 hours, subs
S065X4S	Traum subdr hem w LOC of 6 hours to 24 hours, sequela
S065X5A	Traum subdr hem w LOC >24 hr w ret consc lev, init
S065X5D	Traum subdr hem w LOC >24 hr w ret consc lev, subs
S065X5S	Traum subdr hem w LOC >24 hr w ret consc lev, sequela
S065X6A	Traum subdr hem w LOC >24 hr w/o ret consc w surv, init
S065X6D	Traum subdr hem w LOC >24 hr w/o ret consc w surv, subs
S065X6S	Traum subdr hem w LOC >24 hr w/o ret consc w surv, sequela
S065X9A	Traum subdr hem w LOC of unsp duration, init
S065X9D	Traum subdr hem w LOC of unsp duration, subs
S065X9S	Traum subdr hem w LOC of unsp duration, sequela
S065XAA	Traum subdr hem with LOC status unknown, initial encounter
S065XAD	Traum subdr hem with LOC status unknown, subs
S065XAS	Traum subdr hem with LOC status unknown, sequela
S066X0A	Traum subrac hem w/o loss of consciousness, init
S066X0D	Traum subrac hem w/o loss of consciousness, subs
S066X0S	Traum subrac hem w/o loss of consciousness, sequela
S066X1A	Traum subrac hem w LOC of 30 minutes or less, init
S066X1D	Traum subrac hem w LOC of 30 minutes or less, subs
S066X1S	Traum subrac hem w LOC of 30 minutes or less, sequela

ICD-10-CM Code	Description
S066X2A	Traum subrac hem w loss of consciousness of 31-59 min, init
S066X2D	Traum subrac hem w loss of consciousness of 31-59 min, subs
S066X2S	Traum subrac hem w LOC of 31-59 min, sequela
S066X3A	Traum subrac hem w LOC of 1-5 hrs 59 min, init
S066X3D	Traum subrac hem w LOC of 1-5 hrs 59 min, subs
S066X3S	Traum subrac hem w LOC of 1-5 hrs 59 min, sequela
S066X4A	Traum subrac hem w LOC of 6 hours to 24 hours, init
S066X4D	Traum subrac hem w LOC of 6 hours to 24 hours, subs
S066X4S	Traum subrac hem w LOC of 6 hours to 24 hours, sequela
S066X5A	Traum subrac hem w LOC >24 hr w ret consc lev, init
S066X5D	Traum subrac hem w LOC >24 hr w ret consc lev, subs
S066X5S	Traum subrac hem w LOC >24 hr w ret consc lev, sequela
S066X6A	Traum subrac hem w LOC >24 hr w/o ret consc w surv, init
S066X6D	Traum subrac hem w LOC >24 hr w/o ret consc w surv, subs
S066X6S	Traum subrac hem w LOC >24 hr w/o ret consc w surv, sequela
S066X9A	Traum subrac hem w LOC of unsp duration, init
S066X9D	Traum subrac hem w LOC of unsp duration, subs
S066X9S	Traum subrac hem w LOC of unsp duration, sequela
S066XAA	Traum subrac hem with LOC status unknown, initial encounter
S066XAD	Traum subrac hem with LOC status unknown, subs
S066XAS	Traum subrac hem with LOC status unknown, sequela
S06810A	Injury of r int carotid, intcr w/o LOC, init
S06810D	Injury of r int carotid, intcr w/o LOC, subs
S06810S	Injury of r int carotid, intcr w/o LOC, sequela
S06811A	Inj r int carotid, intcr w LOC of 30 minutes or less, init
S06811D	Inj r int carotid, intcr w LOC of 30 minutes or less, subs
S06811S	Inj r int crtd, intcr w LOC of 30 minutes or less, sequela
S06812A	Injury of r int carotid, intcr w LOC of 31-59 min, init
S06812D	Injury of r int carotid, intcr w LOC of 31-59 min, subs
S06812S	Injury of r int carotid, intcr w LOC of 31-59 min, sequela
S06813A	Injury of r int carotid, intcr w LOC of 1-5 hrs 59 min, init
S06813D	Injury of r int carotid, intcr w LOC of 1-5 hrs 59 min, subs
S06813S	Inj r int carotid, intcr w LOC of 1-5 hrs 59 min, sequela
S06814A	Injury of r int carotid, intcr w LOC of 6-24 hrs, init
S06814D	Injury of r int carotid, intcr w LOC of 6-24 hrs, subs
S06814S	Injury of r int carotid, intcr w LOC of 6-24 hrs, sequela
S06815A	Inj r int carotid, intcr w LOC >24 hr w ret consc lev, init
S06815D	Inj r int carotid, intcr w LOC >24 hr w ret consc lev, subs
S06815S	Inj r int crtd, intcr w LOC >24 hr w ret consc lev, sequela
S06816A	Inj r int crtd,intcr w LOC >24 hr w/o ret consc w surv, init

ICD-10-CM Code	Description
S06816D	Inj r int crtd,intcr w LOC >24 hr w/o ret consc w surv, subs
S06816S	Inj r int crtd,intcr w LOC >24 hr w/o ret consc w surv, sqla
S06819A	Injury of r int carotid, intcr w LOC of unsp duration, init
S06819D	Injury of r int carotid, intcr w LOC of unsp duration, subs
S06819S	Inj r int carotid, intcr w LOC of unsp duration, sequela
S0681AA	Inj r int crtd, intcrn portion, NEC LOC status unknown, init
S0681AD	Inj r int crtd, intcrn portion, NEC LOC status unknown, subs
S0681AS	Inj r int crtd, intcrn portion, NEC LOC status unknown, sqla
S06820A	Injury of l int carotid, intcr w/o LOC, init
S06820D	Injury of l int carotid, intcr w/o LOC, subs
S06820S	Injury of l int carotid, intcr w/o LOC, sequela
S06821A	Inj l int carotid, intcr w LOC of 30 minutes or less, init
S06821D	Inj l int carotid, intcr w LOC of 30 minutes or less, subs
S06821S	Inj l int crtd, intcr w LOC of 30 minutes or less, sequela
S06822A	Injury of l int carotid, intcr w LOC of 31-59 min, init
S06822D	Injury of l int carotid, intcr w LOC of 31-59 min, subs
S06822S	Injury of l int carotid, intcr w LOC of 31-59 min, sequela
S06823A	Injury of l int carotid, intcr w LOC of 1-5 hrs 59 min, init
S06823D	Injury of l int carotid, intcr w LOC of 1-5 hrs 59 min, subs
S06823S	Inj l int carotid, intcr w LOC of 1-5 hrs 59 min, sequela
S06824A	Injury of l int carotid, intcr w LOC of 6-24 hrs, init
S06824D	Injury of l int carotid, intcr w LOC of 6-24 hrs, subs
S06824S	Injury of l int carotid, intcr w LOC of 6-24 hrs, sequela
S06825A	Inj l int carotid, intcr w LOC >24 hr w ret consc lev, init
S06825D	Inj l int carotid, intcr w LOC >24 hr w ret consc lev, subs
S06825S	Inj l int crtd, intcr w LOC >24 hr w ret consc lev, sequela
S06826A	Inj l int crtd,intcr w LOC >24 hr w/o ret consc w surv, init
S06826D	Inj l int crtd,intcr w LOC >24 hr w/o ret consc w surv, subs
S06826S	Inj l int crtd,intcr w LOC >24 hr w/o ret consc w surv, sqla
S06829A	Injury of l int carotid, intcr w LOC of unsp duration, init
S06829D	Injury of l int carotid, intcr w LOC of unsp duration, subs
S06829S	Inj l int carotid, intcr w LOC of unsp duration, sequela
S0682AA	Inj l int crtd, intcrn portion, NEC LOC status unknown, init
S0682AD	Inj l int crtd, intcrn portion, NEC LOC status unknown, subs
S0682AS	Inj l int crtd, intcrn portion, NEC LOC status unknown, sqla
S06890A	Intcran inj w/o loss of consciousness, init encntr
S06890D	Intcran inj w/o loss of consciousness, subs encntr
S06890S	Oth intracranial injury w/o loss of consciousness, sequela
S06891A	Intcran inj w LOC of 30 minutes or less, init
S06891D	Intcran inj w LOC of 30 minutes or less, subs

ICD-10-CM Code	Description
S06891S	Intcran inj w LOC of 30 minutes or less, sequela
S06892A	Intcran inj w loss of consciousness of 31-59 min, init
S06892D	Intcran inj w loss of consciousness of 31-59 min, subs
S06892S	Intcran inj w loss of consciousness of 31-59 min, sequela
S06893A	Intcran inj w loss of consciousness of 1-5 hrs 59 min, init
S06893D	Intcran inj w loss of consciousness of 1-5 hrs 59 min, subs
S06893S	Intcran inj w LOC of 1-5 hrs 59 min, sequela
S06894A	Intcran inj w LOC of 6 hours to 24 hours, init
S06894D	Intcran inj w LOC of 6 hours to 24 hours, subs
S06894S	Intcran inj w LOC of 6 hours to 24 hours, sequela
S06895A	Intcran inj w LOC >24 hr w ret consc lev, init
S06895D	Intcran inj w LOC >24 hr w ret consc lev, subs
S06895S	Intcran inj w LOC >24 hr w ret consc lev, sequela
S06896A	Intcran inj w LOC >24 hr w/o ret consc w surv, init
S06896D	Intcran inj w LOC >24 hr w/o ret consc w surv, subs
S06896S	Intcran inj w LOC >24 hr w/o ret consc w surv, sequela
S06899A	Intcran inj w loss of consciousness of unsp duration, init
S06899D	Intcran inj w loss of consciousness of unsp duration, subs
S06899S	Intcran inj w LOC of unsp duration, sequela
S0689AA	Intcran inj with LOC status unknown, initial encounter
S0689AD	Intcran inj with LOC status unknown, subsequent encounter
S0689AS	Intcran inj with LOC status unknown, sequela
S068A0A	Primary blast injury of brain, NEC without LOC, init
S068A0D	Primary blast injury of brain, NEC without LOC, subs
S068A0S	Primary blast injury of brain, NEC without LOC, sequela
S068A1A	Primary blast inj brain, NEC LOC of 30 minutes or less, init
S068A1D	Primary blast inj brain, NEC LOC of 30 minutes or less, subs
S068A1S	Primary blast inj brain, NEC LOC of 30 min or less, sequela
S068A2A	Primary blast injury of brain, NEC LOC of 31-59 min, init
S068A2D	Primary blast injury of brain, NEC LOC of 31-59 min, subs
S068A2S	Primary blast injury of brain, NEC LOC of 31-59 min, sequela
S068A3A	Primary blast inj brain, NEC LOC of 1-5 hrs 59 min, init
S068A3D	Primary blast inj brain, NEC LOC of 1-5 hrs 59 min, subs
S068A3S	Primary blast inj brain, NEC LOC of 1-5 hrs 59 min, sequela
S068A4A	Primary blast injury of brain, NEC LOC of 6-24 hrs, init
S068A4D	Primary blast injury of brain, NEC LOC of 6-24 hrs, subs
S068A4S	Primary blast injury of brain, NEC LOC of 6-24 hrs, sequela
S068A5A	Prim blst inj brain, NEC LOC >24 hr with ret consc lev, init
S068A5D	Prim blst inj brain, NEC LOC >24 hr with ret consc lev, subs
S068A5S	Prim blst inj brain, NEC LOC >24 hr with ret consc lev, sqla

ICD-10-CM Code	Description
S068A6A	Prim blst inj brn, NEC LOC >24 hr w/o ret consc w surv, init
S068A6D	Prim blst inj brn, NEC LOC >24 hr w/o ret consc w surv, subs
S068A6S	Prim blst inj brn, NEC LOC >24 hr w/o ret consc w surv, sqla
S068A9A	Primary blast inj brain, NEC LOC of unsp duration, init
S068A9D	Primary blast inj brain, NEC LOC of unsp duration, subs
S068A9S	Primary blast inj brain, NEC LOC of unsp duration, sequela
S068AAA	Primary blast injury of brain, NEC LOC status unknown, init
S068AAD	Primary blast injury of brain, NEC LOC status unknown, subs
S068AAS	Primary blast inj brain, NEC LOC status unknown, sequela
S069X0A	Unsp intracranial injury w/o loss of consciousness, init
S069X0D	Unsp intracranial injury w/o loss of consciousness, subs
S069X0S	Unsp intracranial injury w/o loss of consciousness, sequela
S069X1A	Unsp intracranial injury w LOC of 30 minutes or less, init
S069X1D	Unsp intracranial injury w LOC of 30 minutes or less, subs
S069X1S	Unsp intcrn injury w LOC of 30 minutes or less, sequela
S069X2A	Unsp intracranial injury w LOC of 31-59 min, init
S069X2D	Unsp intracranial injury w LOC of 31-59 min, subs
S069X2S	Unsp intracranial injury w LOC of 31-59 min, sequela
S069X3A	Unsp intracranial injury w LOC of 1-5 hrs 59 min, init
S069X3D	Unsp intracranial injury w LOC of 1-5 hrs 59 min, subs
S069X3S	Unsp intracranial injury w LOC of 1-5 hrs 59 min, sequela
S069X4A	Unsp intracranial injury w LOC of 6 hours to 24 hours, init
S069X4D	Unsp intracranial injury w LOC of 6 hours to 24 hours, subs
S069X4S	Unsp intracranial injury w LOC of 6-24 hrs, sequela
S069X5A	Unsp intracranial injury w LOC >24 hr w ret consc lev, init
S069X5D	Unsp intracranial injury w LOC >24 hr w ret consc lev, subs
S069X5S	Unsp intcrn injury w LOC >24 hr w ret consc lev, sequela
S069X6A	Unsp intcrn injury w LOC >24 hr w/o ret consc w surv, init
S069X6D	Unsp intcrn injury w LOC >24 hr w/o ret consc w surv, subs
S069X6S	Unsp intcrn injury w LOC >24 hr w/o ret consc w surv, sqla
S069X9A	Unsp intracranial injury w LOC of unsp duration, init
S069X9D	Unsp intracranial injury w LOC of unsp duration, subs
S069X9S	Unsp intracranial injury w LOC of unsp duration, sequela
S069XAA	Unspecified intcrn injury with LOC status unknown, init
S069XAD	Unspecified intcrn injury with LOC status unknown, subs
S069XAS	Unspecified intcrn injury with LOC status unknown, sequela
S06A0XA	Traumatic brain compression without herniation, init
S06A0XD	Traumatic brain compression without herniation, subs
S06A0XS	Traumatic brain compression without herniation, sequela
S06A1XA	Traumatic brain compression with herniation, init

ICD-10-CM Code	Description
S06A1XD	Traumatic brain compression with herniation, subs
S06A1XS	Traumatic brain compression with herniation, sequela
S070XXA	Crushing injury of face, initial encounter
S070XXD	Crushing injury of face, subsequent encounter
S070XXS	Crushing injury of face, sequela
S071XXA	Crushing injury of skull, initial encounter
S071XXD	Crushing injury of skull, subsequent encounter
S071XXS	Crushing injury of skull, sequela
S078XXA	Crushing injury of other parts of head, initial encounter
S078XXD	Crushing injury of other parts of head, subsequent encounter
S078XXS	Crushing injury of other parts of head, sequela
S079XXA	Crushing injury of head, part unspecified, initial encounter
S079XXD	Crushing injury of head, part unspecified, subs encntr
S079XXS	Crushing injury of head, part unspecified, sequela
S080XXA	Avulsion of scalp, initial encounter
S080XXD	Avulsion of scalp, subsequent encounter
S080XXS	Avulsion of scalp, sequela
R41.840	Attention and concentration deficit
R41.841	Cognitive communication deficit
R41.842	Visuospatial deficit
R41.843	Psychomotor deficit
R41.844	Frontal lobe and executive function deficit
R41.89	Other signs and symptoms involving cognitive functions and awareness
G44.301	Posttraumatic headache, unspecified, intractable

ICD-10-CM Code	Description
G44309	Posttraumatic headache, unspecified, not intractable
G44.321	Chronic posttraumatic headache, unspecified, intractable
G44.329	Chronic posttraumatic headache, unspecified, not intractable
R42.	Dizziness
R43.0	Loss of smell (anosmia)
R43.8	Other disturbance of smell and taste
R47.82	Fluency disorder conditions classified elsewhere
R47.81	Slurred speech
R56.1	Posttraumatic seizures

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	9/11/2025	9/12/2025
Annual Review, no changes	09/30/2026	10/22/2026

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical

policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of Member/enrollees. This clinical policy is not intended to recommend treatment for Member/enrollees. Member/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, Member/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, Member/enrollees and their representatives agree to be bound by such terms and conditions by providing services to Member/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid Member/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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