Easy Choice Health Plan
Harmony Health Plan of Illinois
Missouri Care
‘Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care1st Health Plan Arizona, Inc.)
Staywell of Florida
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)
WellCare Prescription Insurance
WellCare Texan Plus (Medicare – Dallas & Houston markets)

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

BACKGROUND

The National Conference of State Legislatures (2015) states that traumatic brain injury (TBI) is a disruption in the normal functioning of the brain due to a bump, blow, jolt or penetrating head injury. Approximately 1.7-2.5 million people suffer a TBI annually with 50,000 dying. The leading causes of TBI are falls, motor vehicle crashes, being struck by or against objects and assault. While most of these injuries are mild, resulting in a short-term disruption, such as a concussion, many are severe, resulting in prolonged unconsciousness or amnesia and occasionally leading to permanent disability or death. Every year in the United States, TBI is estimated to have direct and indirect costs of $76.5 billion on top of the emotional burden faced by family and friends of someone who suffers a TBI. Many states aim to effectively prevent and diagnose cases of TBI, and to respond and rehabilitate TBI patients.

Clinical Coverage Guideline
Between 2009 and 2015 50 states and the District of Columbia passed laws to address traumatic brain injury. The majority of these states enacted legislation targeting youth sports-related concussions. Other introduced legislation addresses traumatic brain injury in veterans, appropriates funds to traumatic brain injury prevention or treatment programs, and would require insurers, hospitals and health maintenance organizations to provide insurance coverage for survivors of traumatic brain injury. The State of New Jersey defines TBI Behavioral Management as a daily program to service members who display severe maladaptive or aggressive behavior which is potentially destructive to self or others. The program, provided in the home or out of the home, is time-limited and designed to treat the individual and caregivers, if appropriate, on a short-term basis. Behavioral programming includes a complete assessment of the maladaptive behavior(s); development of a structured behavioral modification plan, implementation of the plan, ongoing training and supervision of caregivers and behavioral aides, and periodic reassessment of the plan. The goal of the program is to return the individual to the prior level of functioning which is safe for him/her and others.

**Definition of Traumatic Brain Injury.** A traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event: 

- Any period of loss of or a decreased level of consciousness (LOC);
- Any loss of memory for events immediately before or after the injury (post-traumatic amnesia [PTA]);
- Any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.) (Alteration of consciousness/mental state [AOC]);
- Neurological deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia, etc.) that may or may not be transient
- Intracranial lesion.

External forces may include any of the following events: the head being struck by an object, the head striking an object, the brain undergoing an acceleration/deceleration movement without direct external trauma to the head, a foreign body penetrating the brain, forces generated from events such as a blast or explosion, or other forces yet to be defined. The above criteria define the event of a TBI. Not all individuals exposed to an external force will sustain a TBI, but any person who has a history of such an event with immediate manifestation of any of the above signs and symptoms can be said to have had a TBI.

**Symptomology.** Physical findings, signs and symptoms (“red flags”) may indicate an acute neurologic condition that requires urgent specialty consultation (neurology, neuro-surgical) (DoVA & DoD, 2009):

- Altered consciousness
- Progressively declining neurological examination
- Pupillary asymmetry
- Seizures
- Repeated vomiting
- Double vision
- Worsening headache
- Cannot recognize people or is disoriented to place
- Behaves unusually or seems confused and irritable
- Slurred speech
- Unsteady on feet
- Weakness or numbness in arms / legs

**Symptoms Associated with Concussion / Mild Traumatic Brain Injury (mTBI).** Concussion/mTBI is associated with a variety of symptoms that will manifest immediately following the event, and may resolve quickly, within minutes to hours after the injury event, or they may persist longer. The most typical signs and symptoms after concussion fall into one or more of the following three categories (DoVA & DoD, 2009):

1. **Physical:** headache, nausea, vomiting, dizziness, fatigue, blurred vision, sleep disturbance, sensitivity to light/noise, balance problems, transient neurological abnormalities
2. **Cognitive**: attention, concentration, memory, speed of processing, judgment, executive function
3. **Behavioral**: depression, anxiety, agitation, irritability, impulsivity, aggression.

Signs and symptoms may occur alone or in varying combinations and may result in functional impairment.

**Diagnostic Criteria for mTBI.** In the U.S., the most widely accepted criteria for mild TBI are those proposed by the American College of Rehabilitation Medicine (ACRM, 1993). They are "a physiological disruption of brain function as a result of a traumatic event as manifested by at least one of the following: alteration of mental state, loss of consciousness (LOC), loss of memory or focal neurological deficit, that may or may not be transient; but where the severity of the injury does not exceed the following: post-traumatic amnesia (PTA) for greater than 24 hours, after the first 30 minutes Glasgow Coma Score (GCS) 13 - 15, and loss of consciousness is less than 30 minutes." There are other criteria used by other medical groups. However, most agree that common criteria include GCS score of 13-15, brief LOC, brief PTA and negative head computed tomography (CT) scan. (DoVA & DoD, 2009).

**History, Physical Examination, Laboratory Tests, Imaging.** Taking an accurate history is an essential part of the diagnostic work-up. The first and most critical step in the evaluation of persons with possible concussion symptoms should clearly characterize the initial injury and determine whether the symptoms are temporally related to the event characterized as a concussion/mTBI. (DoVA & DoD, 2009)

1. Individuals who are presumed to have symptoms related to concussion/mTBI or who are identified as positive for mTBI on the initial screening should receive specific assessment of their symptoms.
2. Medical history should include the following:
   - Obtaining detailed information on the patient's symptoms and health concerns.
   - Obtaining detailed information of the injury event including mechanism of injury, duration and severity of alteration of consciousness, immediate symptoms, symptom course and prior treatment
   - Screening for pre-morbid conditions, potential co-occurring conditions or other psychosocial risk factors, such as substance use disorders that may exacerbate or maintain current symptom presentation (using standardized screening tools such as, PHQ-2, Audit-C, PTSD screen)
   - Evaluating signs and symptoms indicating potential for neurosurgical emergencies that require immediate referrals
   - Assessing of danger to self or others.
3. Patient's experiences should be validated by allowing adequate time for building a provider-patient alliance and applying a risk communication approach.

**Physical Examination**

1. The physical examination of the person sustaining a concussion/mTBI should focus on the following:
   - A focused neurologic examination, including a Mental Status Examination (MSE), cranial nerve testing, extremity tone testing, deep tendon reflexes, strength, sensation, and postural stability (Romberg's Test, dynamic standing); AND/OR,
   - A focused vision examination including gross acuity, eye movement, binocular function and visual fields/attention testing; AND/OR,
   - A focused musculoskeletal examination of the head and neck, including range of motion of the neck and jaw, and focal tenderness and referred pain.
2. The following physical findings, signs and symptoms ("Red Flags") may indicate an acute neurologic condition that requires urgent specialty consultation (neurology, neuro-surgical):
   - Altered consciousness
   - Progressively declining neurological examination
   - Pupillary asymmetry
   - Seizures
   - Repeated vomiting
   - Double vision
   - Worsening headache
   - Cannot recognize people or is disoriented to place
• Behaves unusually or seems confused and irritable
• Slurred speech
• Unsteady on feet
• Weakness or numbness in arms/legs.

Laboratory Tests
1. Laboratory testing is not necessary to confirm or manage symptoms associated with concussion/mTBI.
2. Laboratory testing may be considered for evaluating other non-TBI causes of the symptoms presented.
3. There is insufficient evidence to support the use of serum biomarkers for concussion/mTBI in clinical practice.

Imaging. The role of neuroimaging in diagnosing concussion/mTBI continues to evolve and be debated in the literature. Various neuroimaging modalities can be employed in helping to identify structural neuropathology. Structural imaging modalities include Computed Tomography (CT) Scan, Magnetic Resonance Imaging (MRI) Diffusion Tensor Imaging (DTI). Functional imaging modalities include Single Photon Emission Computed Tomography (SPECT), Positron Emission Tomography (PET) and functional MRI (fMRI). However, many of these modalities are still at the preliminary/research stage of development. Currently, CT scan is the modality of choice as a diagnostic tool for acute concussion/mTBI. The absence of abnormal findings on CT does not preclude the presence of concussion/mTBI.

1. A patient who presents with any signs or symptoms that may indicate an acute neurologic condition that requires urgent intervention should be referred for evaluation that may include neuroimaging studies.
2. Neuroimaging is not recommended in patients who sustained a concussion/mTBI beyond the emergency phase (72 hours post-injury) except if the condition deteriorates or red flags are noted.

Noncontrast Computed Tomography (CT) AANN & ARN, 2011
A noncontrast head CT is indicated in head trauma patients with loss of consciousness or posttraumatic amnesia only if one or more of the following is present: headache, vomiting, age greater than 60 years, drug or alcohol intoxication, deficits in short-term memory, physical evidence of trauma above the clavicle, posttraumatic seizure, Glasgow Coma Scale (GCS) score less than 15, focal neurologic deficit, or coagulopathy (Level 1; Jagoda et al., 2008). A noncontrast head CT should be considered in a head trauma patient without loss of consciousness or posttraumatic amnesia if there is a focal neurologic deficit, vomiting, severe headache, age 65 years or greater, physical signs of a basilar skull fracture, GCS score less than 15, coagulopathy, or a dangerous mechanism of injury, including ejection from a motor vehicle, a struck pedestrian, and a fall from a height of more than 3 feet or 5 stairs (Level 2; Jagoda et al., 2008).

CT scans should be protocolized to minimize the exposure of children to radiation (Level 2 recommendation*). Follow CHALICE criteria for pediatric patients 2 years of age or older (see Table 1 in AANN * ARN, 2011); further work is needed to develop evidence-based criteria for CT scans for children under 2 years old (Level 2 recommendation*). (AANN & ARN, 2011; AHRQ, 2011).

Magnetic Resonance Imaging (MRI) AANN & ARN, 2011
With the development of new MRI techniques, earlier diagnosis of patients with clinically significant lesions could lead to earlier implementation of new medical and neuropsychological interventions for the prevention and treatment of post-concussive symptoms (PCS), learning disorders, and psychiatric conditions (Level 3 recommendation*). (AHRQ, 2011).

Patients undergoing magnetic resonance imaging (MRI) scans should be assessed for the presence of ferromagnetic foreign bodies such as metal in the orbits, pacemakers, aneurysm clips, coils and ventricular shunt (VPS) catheters, and implanted pumps or stimulators. The radiologist should be made aware of any of these findings as they may contraindicate the MRI or require posttest reprogramming in that patient. Skull X rays should be obtained for any patient with possible exposure to metal fragments in the orbits prior to obtaining an MRI. Patients with pacemakers may not undergo an MRI as the pacemaker leads may heat the surrounding cardiac tissues and cause damage to the myocardium. Aneurysm clips and coils, besides creating artifact on the image,
may be contraindicated depending on the manufacturer. VPS valves will need to be reset after undergoing an MRI if the valve contains an adjustable magnetic spring device.

^ Level 1: Recommendations are supported by class I evidence.
Level 2: Recommendations are supported by class II evidence.
Level 3: Recommendations are supported by class III and class IV evidence.

Treatment Plan. After the screening, assessment, and diagnosis of concussion/mTBI are completed decisions are made about treatment. Treatment for patients with concussion/mTBI focuses on symptom management and education of patient and family. Education should emphasize recovery, gradual resumption of work and social responsibilities, and teaching compensatory strategies and environmental modifications. As part of the Member’s treatment plan, the Provider shall:

1. Develop and document a summary of the patient’s problems.
2. Develop a potential treatment plan that includes severity and urgency for treatment interventions.
3. Discuss with the patient the general concept of concussion sequelae, treatment options and associated risk/benefits and prognosis of illness to determine the patient’s preferences.
4. Emphasizing good prognosis and empowering the patient for self-management.
5. Implement the treatment plan and follow up.
6. Referral to specialty care is not required in the majority of patients with concussion/mTBI, if their symptoms resolve in the early post-acute recovery period as expected.
7. Treatment should be coordinated and may include consultation with rehabilitation therapists, pharmacy, collaborative mental health, and social support.

POSITION STATEMENT

Applicable To:
☑ Medicaid – New Jersey MLTSS

Participation* into the behavioral management program for members with traumatic brain injury is considered medically necessary and a covered benefit when the following criteria are met:

1. A diagnosis of mTBI should be made when there is an injury to the head as a result of blunt trauma, acceleration or deceleration forces or exposure to blast that result in one or more of the following conditions:
   a. Any period of observed or self-reported:
      • Transient confusion, disorientation, or impaired consciousness
      • Dysfunction of memory immediately before or after the time of injury
      • Loss of consciousness (LOC) lasting less than 30 minutes.
   b. Observed signs of neurological or neuropsychological dysfunction, such as headache, dizziness, irritability, fatigue or poor concentration, when identified soon after injury, can be used to support the diagnosis of mild TBI, but cannot be used to make the diagnosis in the absence of loss of consciousness or altered consciousness.
2. The severity of TBI must be defined by the acute injury characteristics and not by the severity of symptoms at random points after trauma.

* NOTE: Entry to this service is based on medical necessity criteria as defined in the contract. The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who transitions into MLTSS. Program enrollment requires prior evaluation and recommendation of a board-certified and eligible psychiatrist, a licensed neuro-psychologist or neuro-psychiatrist with subsequent consultation by same on an as-needed basis.

3. Services are supervised by and provided by one of the following:
   • Clinical psychologist
   • Board-certified / board-eligible psychiatrist
   • Trained behavioral aides designed
Neuropsychological Testing

Neuropsychological testing shall consist of the following for each age group listed.

**Adult**

For Members with acute brain insult / TBI, all of the following criteria must be met:

1. TBI related brain damage suspected or diagnosed by:
   - Imaging confirmation (e.g., MRI, CT); AND/OR,
   - History of head injury with altered consciousness / post-traumatic amnesia

2. Testing history of one of the following:
   - No prior neuropsychological testing; OR,
   - Prior testing performed 1 to 2 times and a neurological deficit (within a 12 month period) is confirmed by one or more of the following:
     - Unexpected change in symptoms within the last four (4) months and no more than 1 testing episode within the last 12 months; OR,
     - Retesting planned to evaluate response to new treatment and no more than 1 testing episode within the last 12 months; OR,
     - Retesting planned to monitor rehabilitation / functioning and no testing within the last six months

3. Medication or substance use will not confound results as a result of one of the following:
   - Member is on medication and drug effects ruled out as a cause of cognitive impairment; OR,
   - Member has a substance use disorder and a sufficient length of abstinence before testing; OR,
   - Member is taking no medication and/or is not a substance user.

**Children and Adolescents**

For pediatric Members with acute brain insult / TBI, all of the following criteria must be met:

1. TBI related brain damage suspected or diagnosed by:
   - Imaging confirmation (e.g., MRI, CT); AND/OR,
   - History of head injury with altered consciousness / post-traumatic amnesia

2. Testing history of one of the following:
   - No prior neuropsychological testing; OR,
   - Prior testing performed 1 to 2 times and a neurological deficit is confirmed by one or more of the following:
     - Unexpected change in symptoms within the last four (4) months and no more than 1 testing episode within the last 12 months; OR,
     - Retesting planned to evaluate response to new treatment and no more than 1 testing episode within the last 12 months; OR,
3. Medication or substance use will not confound results as a result of one of the following:
   - Member is on medication and drug effects ruled out as a cause of cognitive impairment; OR,
   - Member has a substance use disorder and a sufficient length of abstinence before testing; OR,
   - Member is taking no medication and/or is not a substance user.

* NOTE: Ages are defined as child (4-12), adolescent (13-17), adult (18-65), and geriatric (66 and older).

**CODING**

**Covered CPT© Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>70450</td>
<td>Computed tomography, head or brain; without contrast material</td>
</tr>
<tr>
<td>70554</td>
<td>Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration</td>
</tr>
<tr>
<td>70555</td>
<td>Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing</td>
</tr>
<tr>
<td>70460</td>
<td>Computed tomography, head or brain; with contrast material(s)</td>
</tr>
<tr>
<td>70470</td>
<td>Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections</td>
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<tr>
<td>78607</td>
<td>Brain imaging, tomographic (SPECT)</td>
</tr>
<tr>
<td>78608</td>
<td>Brain imaging, positron emission tomography (PET); metabolic evaluation</td>
</tr>
<tr>
<td>78609</td>
<td>Brain imaging, positron emission tomography (PET); perfusion evaluation</td>
</tr>
<tr>
<td>78647</td>
<td>Cerebrospinal fluid flow, imaging (not including introduction of material); tomographic (SPECT)</td>
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<tr>
<td>96118</td>
<td>Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
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<tr>
<td>96119</td>
<td>Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face</td>
</tr>
<tr>
<td>96120</td>
<td>Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report</td>
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**HCPCS® Codes** – No applicable codes.

**Covered ICD-10-CM codes**

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<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>S01.90xA</td>
<td>Unspecified open wound of unspecified part of head, initial encounter</td>
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<tr>
<td>S02.0xxA – S02.0xxG</td>
<td>Fracture of vault of skull</td>
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<tr>
<td>S02.0xxS</td>
<td>Fracture of vault of skull, sequela</td>
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<td>S02.110A - S02.110B</td>
<td>Type I occipital condyle fracture, unspecified side, initial encounter</td>
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<td>S02.111A - S02.111B</td>
<td>Type II occipital condyle fracture, unspecified side, initial encounter</td>
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<tr>
<td>S02.112A - S02.112B</td>
<td>Type III occipital condyle fracture, unspecified side, initial encounter</td>
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<td>S02.113A - S02.113B</td>
<td>Unspecified occipital condyle fracture, initial encounter</td>
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<tr>
<td>S02.118A - S02.118B</td>
<td>Other fracture of occiput, unspecified side, initial encounter</td>
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<tr>
<td>S02.19xA - S02.19xB</td>
<td>Other fracture of base of skull, initial encounter</td>
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<td>S02.91xA - S02.91xB</td>
<td>Unspecified fracture of skull, initial encounter</td>
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<td>S06.00xA - S06.00xS</td>
<td>Concussion with loss of consciousness of 30 minutes or less</td>
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<td>S06.01xA - S06.01xS</td>
<td>Concussion with loss of consciousness of 30 minutes or less</td>
</tr>
<tr>
<td>S06.09xA - S06.09xS</td>
<td>Concussion with loss of consciousness of unspecified duration</td>
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<tr>
<td>S06.10xA - S06.10xS</td>
<td>Traumatic cerebral edema without loss of consciousness</td>
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<tr>
<td>S06.11xA - S06.11xS</td>
<td>Traumatic cerebral edema with loss of consciousness</td>
</tr>
<tr>
<td>S06.20xA - S06.20xS</td>
<td>Diffuse traumatic brain injury without loss of consciousness</td>
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<tr>
<td>S06.21xA - S06.21xS</td>
<td>Diffuse traumatic brain injury with loss of consciousness</td>
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<td>S06.300A - S06.300S</td>
<td>Unspecified focal traumatic brain injury without loss of consciousness</td>
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<tr>
<td>S06.301A - S06.301S</td>
<td>Unspecified focal traumatic brain injury with loss of consciousness</td>
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<tr>
<td>S06.310A - S06.310S</td>
<td>Contusion and laceration of right cerebral without loss of consciousness</td>
</tr>
<tr>
<td>S06.311A - S06.311S</td>
<td>Contusion and laceration of right cerebral with loss of consciousness</td>
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</tbody>
</table>
S06.320A - S06.320S Contusion and laceration of left cerebrum without loss of consciousness  
S06.321A - S06.321S Contusion and laceration of left cerebrum with loss of consciousness  
S06.330A - S06.330S Contusion and laceration of cerebrum, unspecified, without loss of consciousness  
S06.331A - S06.331S Contusion and laceration of cerebrum, unspecified, with loss of consciousness  
S06.340A - S06.340S Traumatic hemorrhage of right cerebrum without loss of consciousness  
S06.341A - S06.341S Traumatic hemorrhage of right cerebrum with loss of consciousness  
S06.350A - S06.350S Traumatic hemorrhage of left cerebrum without loss of consciousness  
S06.351A - S06.351S Traumatic hemorrhage of left cerebrum with loss of consciousness  
S06.360A - S06.360S Traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness  
S06.361A - S06.361S Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness  
S06.370A - S06.370S Contusion, laceration, and hemorrhage of cerebellum without loss of consciousness  
S06.371A - S06.371S Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness  
S06.380A - S06.380S Contusion, laceration, and hemorrhage of brainstem without loss of consciousness  
S06.381A - S06.381S Contusion, laceration, and hemorrhage of brainstem with loss of consciousness  
S06.400A - S06.400S Epidural hemorrhage without loss of consciousness  
S06.41A - S06.41S Epidural hemorrhage with loss of consciousness  
S06.500A - S06.500S Traumatic subdural hemorrhage without loss of consciousness  
S06.51A - S06.51S Traumatic subdural hemorrhage with loss of consciousness  
S06.60A - S06.60S Traumatic subarachnoid hemorrhage without loss of consciousness  
S06.61A - S06.61S Traumatic subarachnoid hemorrhage with loss of consciousness  
S06.810A - S06.810S Injury of right internal carotid artery, intracranial portion, not elsewhere classified without loss of consciousness  
S06.811A - S06.811S Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness  
S06.820A - S06.820S Injury of left internal carotid artery, intracranial portion, not elsewhere classified without loss of consciousness  
S06.821A - S06.821S Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness  
S06.890A - S06.890S Other specified intracranial injury without loss of consciousness  
S06.891A - S06.891S Other specified intracranial injury with loss of consciousness  
S06.90A - S06.90S Unspecified intracranial injury without loss of consciousness  
S06.91A - S06.91S Unspecified intracranial injury with loss of consciousness  
Z87.820 Personal history of traumatic brain injury  
Z87.828 Personal history of other (healed) physical injury and trauma  
Z91.5 Personal history of self-harm

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES


5. CDC workgroup to improve clinical care of youth with mild TBI. Centers for Disease Control and Prevention Web site.  


Clinical Coverage Guideline


MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>6/29/2014</td>
<td>• Approved by MPC. Clarification of language.</td>
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<tr>
<td>06/5/2014</td>
<td>• Approved by MPC.</td>
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