Local Coverage Determination (LCD): Speech - Language Pathology (SLP) Services: Communication Disorders (L35070)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Novitas Solutions, Inc.	A and B MAC	04111 - MAC A	J - H	Colorado
Novitas Solutions, Inc.	A and B MAC	04112 - MAC B	J - H	Colorado
Novitas Solutions, Inc.	A and B MAC	04211 - MAC A	J - H	New Mexico
Novitas Solutions, Inc.	A and B MAC	04212 - MAC B	J - H	New Mexico
Novitas Solutions, Inc.	A and B MAC	04311 - MAC A	J - H	Oklahoma
Novitas Solutions, Inc.	A and B MAC	04312 - MAC B	J - H	Oklahoma
Novitas Solutions, Inc.	A and B MAC	04411 - MAC A	J - H	Texas
Novitas Solutions, Inc.	A and B MAC	04412 - MAC B	J - H	Texas
Novitas Solutions, Inc.	A and B MAC	04911 - MAC A	J - H	Colorado New Mexico Oklahoma Texas
Novitas Solutions, Inc.	A and B MAC	07101 - MAC A	J - H	Arkansas
Novitas Solutions, Inc.	A and B MAC	07102 - MAC B	J - H	Arkansas
Novitas Solutions, Inc.	A and B MAC	07201 - MAC A	J - H	Louisiana
Novitas Solutions, Inc.	A and B MAC	07202 - MAC B	J - H	Louisiana
Novitas Solutions, Inc.	A and B MAC	07301 - MAC A	J - H	Mississippi
Novitas Solutions, Inc.	A and B MAC	07302 - MAC B	J - H	Mississippi
Novitas Solutions, Inc.	A and B MAC	12101 - MAC A	J - L	Delaware
Novitas Solutions, Inc.	A and B MAC	12102 - MAC B	J - L	Delaware
Novitas Solutions, Inc.	A and B MAC	12201 - MAC A	J - L	District of Columbia
Novitas Solutions, Inc.	A and B MAC	12202 - MAC B	J - L	District of Columbia
Novitas Solutions, Inc.	A and B MAC	12301 - MAC A	J - L	Maryland
Novitas Solutions, Inc.	A and B MAC	12302 - MAC B	J - L	Maryland
Novitas Solutions, Inc.	A and B MAC	12401 - MAC A	J - L	New Jersey
Novitas Solutions, Inc.	A and B MAC	12402 - MAC B	J - L	New Jersey
Novitas Solutions, Inc.	A and B MAC	12501 - MAC A	J - L	Pennsylvania

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Novitas Solutions, Inc.	A and B MAC	12502 - MAC B	J - L	Pennsylvania
Novitas Solutions, Inc.	A and B MAC	12901 - MAC A	J - L	District of Columbia Delaware Maryland New Jersey Pennsylvania

LCD Information

Document Information

LCD ID
L35070

Original ICD-9 LCD ID
L27531

LCD Title
Speech - Language Pathology (SLP) Services: Communication Disorders

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Original Effective Date
For services performed on or after 10/01/2015

Revision Effective Date
For services performed on or after 03/29/2018

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
N/A

Notice Period End Date
N/A

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CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for speech/language services. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for speech/language services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies may be found in the following Internet-Only Manuals (IOMs) published on the CMS Web site.

IOM Citations:

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*,
  - Chapter 8 Coverage of Extended Care (SNF) Services Under Hospital Insurance
  - Chapter 12 Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage
  - Chapter 15, Section 220 Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance and Section 230 Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology
- CMS IOM Publication 100-03, *Medicare National Coverage Determinations Manual*, Part 3, Section 170.2 for Melodic Intonation Therapy
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

- Title XVIII of the Social Security Act, Section 1835(2)(D) outlines requirements for outpatient speech pathology services including certification and recertification of the plan of care.

Federal Register References:

- Title 42 Code of Federal Regulations (CFR), Section 409.32 Criteria for skilled services and the need for skilled services.
- Title 42 CFR, Section 410.61 Plan of treatment requirements for outpatient rehabilitation services.
- Title 42 CFR, Section 424.24(c) Outpatient physical therapy and speech-language pathology services.
- Title 42 CFR, Section 484.4 Personnel qualifications.
- Title 42 CFR, Section 485.705(b)(2) speech-language pathologist qualifications.
- Title 42 CFR, Section 485.715 Condition of participation: Speech pathology services.

Other References:

- Jimmo Settlement information located at www.CMS.gov/Center/Special-Topic/Jimmo-Center.html

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

History/Background and/or General Information

This LCD provides guidelines for selected speech-language pathology (SLP) services for communication disorders.

Please refer to LCD L34891, Speech-Language Pathology (SLP) Services: Dysphagia; Includes VitalStim ® Therapy for services related to dysphagia.

Please refer to LCD L35036, Therapy and Rehabilitation Services (PT, OT) for further coverage information for services represented by CPT codes; 97110, 97530, 97533. 97535, and G0515.

Please refer to LCD L35101, Psychiatric Codes for further coverage information for services represented by CPT codes 96105 and 96111.

The speech-language pathology services discussed in this LCD are those evaluation and therapeutic services necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities; and for the diagnosis and treatment of cognitive communication impairments.

Speech-language pathology services are designed to improve or restore speech and language functioning (communication) following disease, injury or loss of a body part. Clinicians use the clinical history, systems review, physical examination, and a variety of evaluations to characterize individuals with impairments, functional limitations

and disabilities. Impairments, functional limitations and disabilities thus identified are then addressed by the design and implementation of therapeutic interventions tailored to the specific needs of the individual patient.

Covered Indications
Coverage for skilled (speech/language pathology) therapy services does not turn on the presence or absence of a beneficiary's potential for improvement from therapy services, but rather on the beneficiary's need for skilled care. Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. (See 42CFR §409.32) **These skilled services may be necessary to improve the patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.**

In order for SLP services to be considered reasonable and necessary, the following conditions must be met:

- The services must meet accepted standards of practice and be a specific and effective treatment for the patient's condition;
- The services must be skilled services and at a level of complexity, which can be safely and effectively performed only by a qualified SLP;
- For **restorative/rehabilitative therapy*,** there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary to the establishment of a safe and effective maintenance program; and
- In evaluating a claim for skilled therapy that is **restorative/rehabilitative** (i.e., whose goal or purpose is to reverse, in whole or in part, a previous loss of function), it would be entirely appropriate to consider the beneficiary's potential for improvement from the services.
- For **maintenance therapy**,** even if no improvement is expected, skilled therapy services are covered when an individualized assessment of the patient's condition demonstrates that skilled care is necessary for the performance of a safe and effective maintenance program to maintain the patient's current condition or prevent or slow further deterioration.
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice.

***Restorative/Rehabilitative Therapy**
Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, a restoration to a previous level of health and well-being. Therefore, evaluation, re-evaluation and assessment documented in the progress report should describe objective measurements which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment. Improvement is evidenced by successive objective measurements whenever possible.

Rehabilitative therapy requires the skills of a therapist to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation.

Rehabilitative therapy is not required to effect improvement or restoration of function when a patient suffers a transient and easily reversible loss or reduction of function that could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual's illness or injury and the services are not covered.

Documentation must justify the necessity of the services. For example, in the case of rehabilitative therapy, it should be noted that the patient's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

During the last visits for rehabilitative treatment, it may be reasonable and medically necessary for the clinician to develop a maintenance program, and instruct the patient, family member(s) or caregiver(s) in carrying out the maintenance program. Therapy performed repetitively to maintain a level of function that does not require the skills of a therapist is not eligible for reimbursement.

****Maintenance Therapy/Program (skilled)**
Skilled therapy services that do not meet the criteria for rehabilitative therapy may be covered in certain circumstances as maintenance therapy under a maintenance program. Unlike coverage for rehabilitation therapy, coverage of therapy services to carry out a maintenance program does not depend on the presence or absence of the patient's potential for improvement from the therapy. The goals of a maintenance program would be, for example, to maintain functional status or to prevent or slow further deterioration in function. Such skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgement, knowledge, and skills of a qualified therapist are necessary for the performance of the maintenance therapy services.

A service is not considered a skilled therapy service merely because it is furnished by a therapist or under the direct supervision of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service.

Documentation must justify the necessity of the services. For example, in the case of maintenance therapy, it should be noted that the treatment by the therapist is necessary to maintain, prevent or slow further deterioration of the patient's functional status and the services cannot be safely carried out by the beneficiary him or herself, a family member, another caregiver or unskilled personnel.

In situations where the maintenance program is performed to maintain the patient's current condition, such documentation would serve to demonstrate the program's effectiveness in achieving this goal. When the maintenance program is intended to slow further deterioration of the patient's condition, the efficacy of the services could be established by documenting that the natural progression of the patient's medical or functional decline has been interrupted.

SLP EVALUATION AND DIAGNOSTIC SERVICES

Medicare provides reimbursement for an evaluation that is reasonable and necessary for the clinician to determine if there is an expectation that the services will be appropriate for the patient's condition. The evaluation of a patient's level of function is focused on identifying what the patient wants and needs to do, and on identifying those factors that help or hinder the performance of those activities. During the first patient contact, the clinician evaluates and documents:

- A diagnosis (where allowed) and description of the specific problem to be evaluated or treated. This should include the specific body area(s) evaluated. Include all conditions and complexities that may impact the treatment. A description might include, for example, the pre-morbid function, date of onset, and current function;
- Objective measurements, preferably standardized patient assessment instruments or outcomes measurement tools related to current functional status, when these are available and appropriate to the condition being evaluated;
- Clinician's clinical judgments or subjective impressions that describe the current functional status of the

condition being evaluated, when they provide further information to supplement measurement tools; and
- A determination that treatment is not needed, or, if rehabilitative treatment is needed a prognosis for return to pre-morbid condition or maximum expected condition with expected time frame and a plan of care. If evaluating a patient for maintenance therapy, please refer to the "Maintenance Therapy/Program (skilled)" section above for requirements.

A re-evaluation is the re-assessment of the patient's performance and goals, after an intervention plan has been instituted, in order to determine the type and amount of change in treatments if needed. A re-evaluation may be indicated during an episode of care when a significant improvement, decline, or change in the patient's condition occurs. Re-evaluation requires the same professional skill as evaluation.

The decision to provide a re-evaluation shall be made by the clinician making a professional judgment about continued care, modifying goals or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Re-evaluations are usually focused on the current treatment and may not be as extensive as initial evaluations. Re-evaluations may be appropriate at a planned discharge.

Continuous assessment of the patient's progress is a component of ongoing rehabilitative therapy services, and is not a re-evaluation. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals or treatment or terminating services. Documentation should state the clinical reasons progress cannot be shown. Periodic re-evaluations of maintenance programs may be covered when deemed necessary, if they require the skills of the SLP, and they are a distinct and separately identifiable service which can only be done safely by the SLP.

Current Procedural Terminology does not define a re-evaluation code for speech language pathology; the evaluation code should be used. The documentation should differentiate between evaluation/re-evaluation and screening. **Screening assessments are non-covered.**

Speech/hearing evaluation (CPT codes 92521, 92522, 92523, 92524)

In addition to the general information above, the evaluation includes the identification, assessment, diagnosis, and evaluation for disorders of: speech, articulation, fluency, and voice (including respiration, phonation, and resonance); language skills (involving the parameters of phonology, morphology, syntax, semantics, and pragmatics, and including disorders of receptive and expressive communication in oral, written, graphic, and manual modalities); and cognitive aspects of communication (including communication disability and other functional disabilities associated with cognitive impairment).

Speech / hearing evaluation for disorders of the auditory system may also be considered here, such as auditory processing evaluation. Please see CMS IOM Pub. 100-02, Chapter 15, Section 220, referenced in the CMS National Coverage Policy section, above, for further details. One portion of the instruction is shown below:

> Assessment for the need for rehabilitation of the auditory system (but not the vestibular system) may be done by a speech language pathologist. Examples include but are not limited to: evaluation of comprehension and production of language in oral, signed, or written modalities, speech and voice production, listening skills, speech reading, communications strategies, and the impact of the hearing loss on the patient/client and family. [Later in the next paragraph it continues:] In determining the necessity for treatment, the beneficiary's performance in both clinical and natural environment should be considered.

Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech (CPT code 92597)

This includes selection of a standard or indwelling voice prosthesis, determination of appropriate size prosthesis and fitting a tracheostomy valve. Includes instructions for care and cleaning.

Evaluation of patient for prescription of speech-generating devices (CPT codes 92607, 92608)

This includes evaluation of language comprehension and production across modalities: written, spoken, and gestural. May also include evaluation of motor skills and nonverbal communication strategies (e.g. words, pictures, and vocalizations). Includes evaluation of the ability to operate and effectively use a speech generating device or aid.

Assessment of Aphasia (CPT 96105)

This includes the assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, and writing, with interpretation and report (per hour). Examples of assessments used include the Boston Diagnostic Aphasia Examination, the Western Aphasia Battery, and the Minnesota Differential Diagnosis Examination of Aphasia.

A comprehensive aphasia assessment is generally covered once. Monthly or regular re-evaluations conducted to determine or document progress, e.g., Western Aphasia Battery, for a patient undergoing a restorative SLP program, are to be considered a part of the treatment session and would not be covered as a separate evaluation for billing purposes. For patients with severe aphasia, comprehensive assessments such as those listed above would not be performed routinely without documentation explaining the need.

Developmental testing; extended (CPT code 96111)

This includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments; with interpretation and report.

Standardized cognitive performance testing (CPT code 96125)

This includes testing such as the Ross Information Processing Assessment (per hour) including both face-to-face time and non-face-to-face time interpreting these test results and preparing the report. Standardized tests may be norm-referenced (results are interpreted based on established norms and compare test-takers to each other) or criterion-referenced (results are interpreted based on the person’s performance/ability to complete tasks or demonstrate knowledge of a specific topic).

SLP THERAPEUTIC SERVICES

Speech/hearing therapy (CPT code 92507)

The treatment/intervention, (e.g., prevention, restoration, amelioration, and compensation) and follow-up services for disorders of speech, articulation, fluency and voice, language skills and the cognitive aspect of communication.

1. Providing consultation, counseling, and making referrals when appropriate.
2. Providing training and support to family members/caregivers and other communication partners of individuals

with speech, voice, language, communication, fluency and hearing disabilities.
3. Developing and establishing effective augmentative and alternative communication techniques and strategies, including selecting, prescribing and dispensing of aids and devices as identified by State Practice Acts; and training individuals, their family members/caregivers, and other communication partners in their use.
4. Establishing effective use of appropriate prosthetic/adaptive devices for speaking.
5. Providing rehabilitation services for the auditory system, and related counseling services to individuals with hearing loss and to their family members/caregivers. Please see IOM Pub. 100-02, Chapter 15, Section 220, referenced in the CMS National Coverage Policy section, above, for further details. One portion of the instruction states: "Examples of rehabilitation include but are not limited to treatment that focuses on comprehension, and production of language in oral, signed or written modalities; speech and voice production, auditory training, speech reading, multimodal (e.g., visual, auditory-visual, and tactile) training, communication strategies, education and counseling."
6. Providing interventions for individuals with central auditory processing disorders; and /or
7. Modification or training in use of voice prosthetic. Modifications in voice prosthetic to supplement oral speech would be appropriate and should be carried out by a speech-language pathologist. The patient is seen for sizing, fitting, placement or replacement and training of the voice prosthetic.

Speech/hearing therapy (group) (CPT code 92508)

For the purpose of performing group therapy, a group is defined as two to four patients receiving active therapy, but not one-on-one treatment; and the patients may be performing the same therapy, or a different therapy, but the speech-language pathologist is instructing all the patients in the group. Group therapy services are rendered under an individualized plan of care, and are integral to the achievement of the patient's individualized goals. Further, the skills of the SLP are required to safely or effectively carry out the group services; the group therapy satisfies all of the "reasonable and necessary criteria" listed under Indications and Limitations of Coverage and; group therapy accounts for no more than 25% of the patient's total time in therapy.

Therapeutic services (patient adaptation and training) for the use of speech-generating devices (CPT code 92609)

Patient adaptation and training for the use of speech-generating devices includes the development of operational competence in using a speech-generating device or aids, to include customizing the features of the device to meet the specific communication needs of each patient and providing opportunities for developing skill in all aspects of device use.

SLP THERAPEUTIC PROCEDURES

Therapeutic procedures are treatments that attempt to reduce impairments and improve or maintain function (or prevent further deterioration) through the application of clinical skills or services. Use of these procedures requires that the therapist have direct (one-on-one) patient contact. Common components included as part of the therapeutic procedures include chart reviews for treatment, set up of activities and the equipment area, and review of previous documentation as needed. Also included is communication with other health care professionals, discussions with family, and calls to the referring physician for additional information or clarification. Subsequent to providing the therapeutic service, the treatment is recorded, and typically the expected result is documented.

Therapeutic exercises and therapeutic activities are examples of therapeutic interventions. The expected goals must be documented in the treatment plan, and affected by the use of each of these procedures, in order to define whether these procedures are reasonable and necessary. Therefore, since one, or a combination of more than one of these modalities may be used in the treatment plan, documentation must support the use of each treatment or

modality as it relates to a specific therapeutic goal.

Services provided concurrently by different types of clinicians may be covered if separate and distinct goals are documented in the treatment plans.

Therapeutic exercises (CPT code 97110)

Therapeutic exercise incorporates rehabilitation principles related to strengthening, endurance, flexibility, and range of motion. Therapeutic exercise may be performed with a patient either actively, actively assisted, or passively participating. Therapeutic exercises may be used to strengthen muscles (e.g., jaw, tongue, facial).

Therapeutic activities (CPT code 97530)

Therapeutic activities involve the use of dynamic activities to improve functional performance in a progressive manner; e.g., increase in volume of voice through respiratory activities. They require the skills of a clinician and are designed to address a specific functional need of the patient.

In order for therapeutic activities to be covered, all of the following requirements must be met:

- the patient has a condition for which therapeutic activities are medically reasonable and necessary as stated in the covered indications and can only be performed under the direct supervision of a clinician; and
- there is a clear correlation between the type of exercise performed and the patient's underlying functional deficit(s) for which the therapeutic activities were prescribed.

Cognitive skills development (CPT code G0515)

This code describes interventions used to improve, maintain, or prevent further deterioration of cognitive skills, (e.g., attention, memory, problem solving) with direct (one-on-one) patient contact by the clinician. It may be medically necessary for patients with acquired cognitive impairments from head trauma, acute neurological events (including cerebrovascular accidents), or other neurological disease.

As stated earlier, speech-language pathology services are covered when the services meet the medically reasonable and necessary criteria as stated in the covered indications.

Sensory integrative techniques (CPT code 97533)

This activity focuses on sensory integrative techniques to enhance sensory processing and to promote adaptive responses to environmental demands, with direct (one-on-one) patient contact by the clinician. When a patient has a deficit in processing input from a sensory system (e.g., vestibular, proprioceptive, tactile), it may decrease the patient's ability to make adaptive sensory, motor, and behavioral responses to environmental demands. An example is a patient with several oral problems secondary to a stroke; the sensory integrative techniques used to facilitate speech might include icing or brushing techniques.

Self-care/home management training (CPT code 97535)

This training includes activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment, direct one-on-one contact by the clinician. The patient must have a condition for which training in activities of daily living is reasonable and necessary, and meet the criteria as stated in the covered indications.

Limitations

The following are considered not reasonable and necessary and therefore will be denied:

1. Therapy performed repetitively to maintain a level of function that does not require the skills of a therapist (unskilled procedure[s]*) is not eligible for reimbursement. When the individualized assessment does not demonstrate a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services do not constitute a covered level of care.

    *Examples of Unskilled Procedures: These services do not require the skills of a SLP and are not covered by Medicare. These include:

    • Non-diagnostic/non-therapeutic routine, repetitive and reinforced procedures, e.g., the practicing of word drills without skilled feedback;
    • procedures that are repetitive or reinforcing of previously learned material which the patient or family is instructed to repeat;
    • procedures that may be effectively carried out with the patient by any nonprofessional, e.g., family member or restorative nursing aide after instruction and training is completed; and
    • supervision of the patient practicing the use of augmentative or alternative communication systems.

2. Screening assessments are noncovered and should not be billed. Generally, social or support groups such as "stroke clubs" or "lost cord clubs" are not reimbursable. For patients with severe aphasia, comprehensive aphasia assessments would not be performed routinely without documentation explaining the need.
3. Routine screening for hearing acuity or evaluations aimed at the use of hearing aids are not considered covered services. Therapy services and supplies directed toward the operation, use, maintenance or management of a hearing aid or other amplification device are excluded under §1862 (a)(7) of the Social Security Act, which prohibits coverage of any expenses incurred for items or services where such expenses are for hearing aids or examinations.
4. The service represented by procedure code 96110 is a screening service. Screening services are excluded from Medicare coverage unless identified specifically as covered by CMS; therefore, procedure code 96110 is non-covered by Medicare.

Notice: This LCD imposes diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

As published in CMS IOM 100-08, Chapter 13, Section 13.5.1, in order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary if the contractor determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
    - Furnished in a setting appropriate to the patient's medical needs and condition.
    - Ordered and furnished by qualified personnel.
    - One that meets, but does not exceed, the patient's medical needs.
    - At least as beneficial as an existing and available medically appropriate alternative.

The redetermination process may be utilized for consideration of services performed outside of the reasonable and necessary requirements in this LCD.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type.Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

CODE	DESCRIPTION
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
018x	Hospital - Swing Beds
021x	Skilled Nursing - Inpatient (Including Medicare Part A)
022x	Skilled Nursing - Inpatient (Medicare Part B only)

CODE	DESCRIPTION
023x	Skilled Nursing - Outpatient
074x	Clinic - Outpatient Rehabilitation Facility (ORF)
075x	Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
083x	Ambulatory Surgery Center
085x	Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Note: The contractor has identified the Bill Type and Revenue Codes applicable for use with the CPT/HCPCS codes included in this LCD. Providers are reminded that not all CPT/HCPCS codes listed can be billed with all Bill Type and/or Revenue Codes listed. CPT/HCPCS codes are required to be billed with specific Bill Type and Revenue Codes. Providers are encouraged to refer to the CMS Internet-Only Manual (IOM) Pub. 100-04, *Medicare Claims Processing Manual*, for further guidance.

CODE	DESCRIPTION
0440	Speech-Language Pathology - General Classification
0441	Speech-Language Pathology - Visit
0442	Speech-Language Pathology - Hourly
0443	Speech-Language Pathology - Group
0444	Speech-Language Pathology - Evaluation or Reevaluation
0449	Speech-Language Pathology - Other Speech Therapy

CPT/HCPCS Codes

Group 1 Paragraph:

Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.

The following CPT/HCPCS codes associated with the services outlined in this policy will not have diagnosis limitations applied at this time: 96125, 97110, 97530, 97533, 97535, and G0515.

Group 1 Codes:

CODE	DESCRIPTION
92507	Speech/hearing therapy

CODE	DESCRIPTION
92508	Speech/hearing therapy
92521	Evaluation of speech fluency
92522	Evaluate speech production
92523	Speech sound lang comprehen
92524	Behavral qualit analys voice
92597	Oral speech device eval
92607	Ex for speech device rx 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
96105	Assessment of aphasia
96111	Developmental test extend

Group 2 Paragraph:

Non-Covered Services

Group 2 Codes:

CODE	DESCRIPTION
96110	Developmental screen w/score

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph:

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

Medicare is establishing the following limited coverage for all the following **CPT/HCPCS codes: 92507, 92508, 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92609, 96105*, and 96111*.**

***Note**: CPT codes 96105 and 96111 have additional diagnoses available for coverage listed in LCD L35101, Psychiatric Codes.

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
A69.0	Necrotizing ulcerative stomatitis
C09.0	Malignant neoplasm of tonsillar fossa
C09.1	Malignant neoplasm of tonsillar pillar (anterior) (posterior)
C09.8	Malignant neoplasm of overlapping sites of tonsil

ICD-10 CODE	DESCRIPTION
C09.9	Malignant neoplasm of tonsil, unspecified
C10.0	Malignant neoplasm of vallecula
C10.1	Malignant neoplasm of anterior surface of epiglottis
C10.2	Malignant neoplasm of lateral wall of oropharynx
C10.3	Malignant neoplasm of posterior wall of oropharynx
C10.4	Malignant neoplasm of branchial cleft
C10.8	Malignant neoplasm of overlapping sites of oropharynx
C10.9	Malignant neoplasm of oropharynx, unspecified
C12	Malignant neoplasm of pyriform sinus
C13.0	Malignant neoplasm of postcricoid region
C13.1	Malignant neoplasm of aryepiglottic fold, hypopharyngeal aspect
C13.2	Malignant neoplasm of posterior wall of hypopharynx
C13.8	Malignant neoplasm of overlapping sites of hypopharynx
C13.9	Malignant neoplasm of hypopharynx, unspecified
C14.0	Malignant neoplasm of pharynx, unspecified
C14.2	Malignant neoplasm of Waldeyer's ring
C14.8	Malignant neoplasm of overlapping sites of lip, oral cavity and pharynx
C32.0	Malignant neoplasm of glottis
C32.1	Malignant neoplasm of supraglottis
C32.2	Malignant neoplasm of subglottis
C32.3	Malignant neoplasm of laryngeal cartilage
C32.8	Malignant neoplasm of overlapping sites of larynx
C32.9	Malignant neoplasm of larynx, unspecified
D14.1	Benign neoplasm of larynx
D38.0	Neoplasm of uncertain behavior of larynx
F01.50	Vascular dementia without behavioral disturbance
F01.51	Vascular dementia with behavioral disturbance
F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance
F03.90	Unspecified dementia without behavioral disturbance
F03.91	Unspecified dementia with behavioral disturbance
F05	Delirium due to known physiological condition

ICD-10 CODE	DESCRIPTION
F06.0	Psychotic disorder with hallucinations due to known physiological condition
F06.1	Catatonic disorder due to known physiological condition
F06.8	Other specified mental disorders due to known physiological condition
F07.0	Personality change due to known physiological condition
F07.89	Other personality and behavioral disorders due to known physiological condition
F48.2	Pseudobulbar affect
F80.0	Phonological disorder
F80.1	Expressive language disorder
F80.2	Mixed receptive-expressive language disorder
F80.4	Speech and language development delay due to hearing loss
F80.81	Childhood onset fluency disorder
F80.89	Other developmental disorders of speech and language
F80.9	Developmental disorder of speech and language, unspecified
F81.0	Specific reading disorder
F81.2	Mathematics disorder
F81.81	Disorder of written expression
F81.89	Other developmental disorders of scholastic skills
F82	Specific developmental disorder of motor function
F88	Other disorders of psychological development
F95.2	Tourette's disorder
F98.5	Adult onset fluency disorder
G10	Huntington's disease
G12.21	Amyotrophic lateral sclerosis
G12.25	Progressive spinal muscle atrophy
G13.2	Systemic atrophy primarily affecting the central nervous system in myxedema
G13.8	Systemic atrophy primarily affecting central nervous system in other diseases classified elsewhere
G20	Parkinson's disease
G21.0	Malignant neuroleptic syndrome
G21.11	Neuroleptic induced parkinsonism
G21.19	Other drug induced secondary parkinsonism
G21.2	Secondary parkinsonism due to other external agents

ICD-10 CODE	DESCRIPTION
G21.3	Postencephalitic parkinsonism
G21.4	Vascular parkinsonism
G21.8	Other secondary parkinsonism
G21.9	Secondary parkinsonism, unspecified
G23.0	Hallervorden-Spatz disease
G23.1	Progressive supranuclear ophthalmoplegia [Steele-Richardson-Olszewski]
G23.2	Striatonigral degeneration
G23.8	Other specified degenerative diseases of basal ganglia
G23.9	Degenerative disease of basal ganglia, unspecified
G24.01	Drug induced subacute dyskinesia
G24.1	Genetic torsion dystonia
G24.3	Spasmodic torticollis
G24.4	Idiopathic orofacial dystonia
G24.5	Blepharospasm
G24.9	Dystonia, unspecified
G25.3	Myoclonus
G25.4	Drug-induced chorea
G25.5	Other chorea
G25.70	Drug induced movement disorder, unspecified
G25.71	Drug induced akathisia
G25.79	Other drug induced movement disorders
G25.81	Restless legs syndrome
G25.82	Stiff-man syndrome
G25.83	Benign shuddering attacks
G25.89	Other specified extrapyramidal and movement disorders
G25.9	Extrapyramidal and movement disorder, unspecified
G26	Extrapyramidal and movement disorders in diseases classified elsewhere
G30.0	Alzheimer's disease with early onset
G30.1	Alzheimer's disease with late onset
G30.8	Other Alzheimer's disease
G30.9	Alzheimer's disease, unspecified
G31.01	Pick's disease

ICD-10 CODE	DESCRIPTION
G31.09	Other frontotemporal dementia
G31.1	Senile degeneration of brain, not elsewhere classified
ICD-10 CODE	DESCRIPTION
G31.2	Degeneration of nervous system due to alcohol
G31.83	Dementia with Lewy bodies
G31.84	Mild cognitive impairment, so stated
G31.85	Corticobasal degeneration
G31.89	Other specified degenerative diseases of nervous system
G31.9	Degenerative disease of nervous system, unspecified
G36.0	Neuromyelitis optica [Devic]
G36.1	Acute and subacute hemorrhagic leukoencephalitis [Hurst]
G36.8	Other specified acute disseminated demyelination
G36.9	Acute disseminated demyelination, unspecified
G37.0	Diffuse sclerosis of central nervous system
G37.1	Central demyelination of corpus callosum
G37.2	Central pontine myelinolysis
G37.3	Acute transverse myelitis in demyelinating disease of central nervous system
G37.4	Subacute necrotizing myelitis of central nervous system
G37.5	Concentric sclerosis [Balo] of central nervous system
G37.8	Other specified demyelinating diseases of central nervous system
G37.9	Demyelinating disease of central nervous system, unspecified
G45.0	Vertebro-basilar artery syndrome
G45.1	Carotid artery syndrome (hemispheric)
G45.2	Multiple and bilateral precerebral artery syndromes
G45.8	Other transient cerebral ischemic attacks and related syndromes
G45.9	Transient cerebral ischemic attack, unspecified
G46.0	Middle cerebral artery syndrome
G46.1	Anterior cerebral artery syndrome
G46.2	Posterior cerebral artery syndrome
G52.1	Disorders of glossopharyngeal nerve
G52.2	Disorders of vagus nerve
G52.3	Disorders of hypoglossal nerve

ICD-10 CODE	DESCRIPTION
G52.7	Disorders of multiple cranial nerves
G52.8	Disorders of other specified cranial nerves
G60.8	Other hereditary and idiopathic neuropathies
G81.00	Flaccid hemiplegia affecting unspecified side
G81.01	Flaccid hemiplegia affecting right dominant side
G81.02	Flaccid hemiplegia affecting left dominant side
G81.03	Flaccid hemiplegia affecting right nondominant side
G81.04	Flaccid hemiplegia affecting left nondominant side
G81.10	Spastic hemiplegia affecting unspecified side
G81.11	Spastic hemiplegia affecting right dominant side
G81.12	Spastic hemiplegia affecting left dominant side
G81.13	Spastic hemiplegia affecting right nondominant side
G81.14	Spastic hemiplegia affecting left nondominant side
G81.90	Hemiplegia, unspecified affecting unspecified side
G81.91	Hemiplegia, unspecified affecting right dominant side
G81.92	Hemiplegia, unspecified affecting left dominant side
G81.93	Hemiplegia, unspecified affecting right nondominant side
G81.94	Hemiplegia, unspecified affecting left nondominant side
G90.1	Familial dysautonomia [Riley-Day]
G90.3	Multi-system degeneration of the autonomic nervous system
G91.0	Communicating hydrocephalus
G91.1	Obstructive hydrocephalus
G91.2	(Idiopathic) normal pressure hydrocephalus
G91.3	Post-traumatic hydrocephalus, unspecified
G91.4	Hydrocephalus in diseases classified elsewhere
G91.8	Other hydrocephalus
G91.9	Hydrocephalus, unspecified
G93.7	Reye's syndrome
G94	Other disorders of brain in diseases classified elsewhere
H90.0	Conductive hearing loss, bilateral
H90.11	Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side

ICD-10 CODE	DESCRIPTION
H90.12	Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
H90.2	Conductive hearing loss, unspecified
H90.3	Sensorineural hearing loss, bilateral
H90.41	Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
H90.42	Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
H90.5	Unspecified sensorineural hearing loss
H90.6	Mixed conductive and sensorineural hearing loss, bilateral
H90.71	Mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
H90.72	Mixed conductive and sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
H90.8	Mixed conductive and sensorineural hearing loss, unspecified
H90.A11	Conductive hearing loss, unilateral, right ear with restricted hearing on the contralateral side
H90.A12	Conductive hearing loss, unilateral, left ear with restricted hearing on the contralateral side
H90.A21	Sensorineural hearing loss, unilateral, right ear, with restricted hearing on the contralateral side
H90.A22	Sensorineural hearing loss, unilateral, left ear, with restricted hearing on the contralateral side
H90.A31	Mixed conductive and sensorineural hearing loss, unilateral, right ear with restricted hearing on the contralateral side
H90.A32	Mixed conductive and sensorineural hearing loss, unilateral, left ear with restricted hearing on the contralateral side
H93.241	Temporary auditory threshold shift, right ear
H93.242	Temporary auditory threshold shift, left ear
H93.243	Temporary auditory threshold shift, bilateral
H93.249	Temporary auditory threshold shift, unspecified ear
H93.25	Central auditory processing disorder
H93.291	Other abnormal auditory perceptions, right ear
H93.292	Other abnormal auditory perceptions, left ear
H93.293	Other abnormal auditory perceptions, bilateral

ICD-10 CODE	DESCRIPTION
H93.299	Other abnormal auditory perceptions, unspecified ear
H93.90	Unspecified disorder of ear, unspecified ear
H93.91	Unspecified disorder of right ear
H93.92	Unspecified disorder of left ear
H93.93	Unspecified disorder of ear, bilateral
I67.841	Reversible cerebrovascular vasoconstriction syndrome
I67.848	Other cerebrovascular vasospasm and vasoconstriction
I67.89	Other cerebrovascular disease
I69.010	Attention and concentration deficit following nontraumatic subarachnoid hemorrhage
I69.011	Memory deficit following nontraumatic subarachnoid hemorrhage
I69.013	Psychomotor deficit following nontraumatic subarachnoid hemorrhage
I69.014	Frontal lobe and executive function deficit following nontraumatic subarachnoid hemorrhage
I69.018	Other symptoms and signs involving cognitive functions following nontraumatic subarachnoid hemorrhage
I69.020	Aphasia following nontraumatic subarachnoid hemorrhage
I69.021	Dysphasia following nontraumatic subarachnoid hemorrhage
I69.022	Dysarthria following nontraumatic subarachnoid hemorrhage
ICD-10 CODE	DESCRIPTION
I69.023	Fluency disorder following nontraumatic subarachnoid hemorrhage
I69.028	Other speech and language deficits following nontraumatic subarachnoid hemorrhage
I69.090	Apraxia following nontraumatic subarachnoid hemorrhage
I69.092	Facial weakness following nontraumatic subarachnoid hemorrhage
I69.110	Attention and concentration deficit following nontraumatic intracerebral hemorrhage
I69.111	Memory deficit following nontraumatic intracerebral hemorrhage
I69.113	Psychomotor deficit following nontraumatic intracerebral hemorrhage
I69.114	Frontal lobe and executive function deficit following nontraumatic intracerebral hemorrhage
I69.118	Other symptoms and signs involving cognitive functions following nontraumatic intracerebral hemorrhage
I69.120	Aphasia following nontraumatic intracerebral hemorrhage
I69.121	Dysphasia following nontraumatic intracerebral hemorrhage

ICD-10 CODE	DESCRIPTION
I69.122	Dysarthria following nontraumatic intracerebral hemorrhage
I69.123	Fluency disorder following nontraumatic intracerebral hemorrhage
I69.128	Other speech and language deficits following nontraumatic intracerebral hemorrhage
I69.190	Apraxia following nontraumatic intracerebral hemorrhage
I69.192	Facial weakness following nontraumatic intracerebral hemorrhage
I69.210	Attention and concentration deficit following other nontraumatic intracranial hemorrhage
I69.211	Memory deficit following other nontraumatic intracranial hemorrhage
I69.213	Psychomotor deficit following other nontraumatic intracranial hemorrhage
I69.214	Frontal lobe and executive function deficit following other nontraumatic intracranial hemorrhage
I69.218	Other symptoms and signs involving cognitive functions following other nontraumatic intracranial hemorrhage
I69.220	Aphasia following other nontraumatic intracranial hemorrhage
I69.221	Dysphasia following other nontraumatic intracranial hemorrhage
I69.222	Dysarthria following other nontraumatic intracranial hemorrhage
I69.223	Fluency disorder following other nontraumatic intracranial hemorrhage
I69.228	Other speech and language deficits following other nontraumatic intracranial hemorrhage
I69.290	Apraxia following other nontraumatic intracranial hemorrhage
I69.292	Facial weakness following other nontraumatic intracranial hemorrhage
I69.310	Attention and concentration deficit following cerebral infarction
I69.311	Memory deficit following cerebral infarction
I69.313	Psychomotor deficit following cerebral infarction
I69.314	Frontal lobe and executive function deficit following cerebral infarction
I69.318	Other symptoms and signs involving cognitive functions following cerebral infarction
I69.320	Aphasia following cerebral infarction
I69.321	Dysphasia following cerebral infarction
I69.322	Dysarthria following cerebral infarction
I69.323	Fluency disorder following cerebral infarction
I69.328	Other speech and language deficits following cerebral infarction
I69.390	Apraxia following cerebral infarction
I69.392	Facial weakness following cerebral infarction

ICD-10 CODE	DESCRIPTION
I69.810	Attention and concentration deficit following other cerebrovascular disease
I69.811	Memory deficit following other cerebrovascular disease
I69.813	Psychomotor deficit following other cerebrovascular disease
I69.814	Frontal lobe and executive function deficit following other cerebrovascular disease
I69.818	Other symptoms and signs involving cognitive functions following other cerebrovascular disease
I69.820	Aphasia following other cerebrovascular disease
I69.821	Dysphasia following other cerebrovascular disease
I69.822	Dysarthria following other cerebrovascular disease
I69.823	Fluency disorder following other cerebrovascular disease
I69.828	Other speech and language deficits following other cerebrovascular disease
I69.890	Apraxia following other cerebrovascular disease
I69.892	Facial weakness following other cerebrovascular disease
I69.910	Attention and concentration deficit following unspecified cerebrovascular disease
I69.911	Memory deficit following unspecified cerebrovascular disease
I69.913	Psychomotor deficit following unspecified cerebrovascular disease
I69.914	Frontal lobe and executive function deficit following unspecified cerebrovascular disease
I69.918	Other symptoms and signs involving cognitive functions following unspecified cerebrovascular disease
I69.920	Aphasia following unspecified cerebrovascular disease
I69.921	Dysphasia following unspecified cerebrovascular disease
I69.922	Dysarthria following unspecified cerebrovascular disease
I69.923	Fluency disorder following unspecified cerebrovascular disease
I69.928	Other speech and language deficits following unspecified cerebrovascular disease
I69.990	Apraxia following unspecified cerebrovascular disease
I69.992	Facial weakness following unspecified cerebrovascular disease
J04.0	Acute laryngitis
J04.10	Acute tracheitis without obstruction
J04.11	Acute tracheitis with obstruction
J04.2	Acute laryngotracheitis
J04.30	Supraglottitis, unspecified, without obstruction
J04.31	Supraglottitis, unspecified, with obstruction

ICD-10 CODE	DESCRIPTION
J05.0	Acute obstructive laryngitis [croup]
J05.10	Acute epiglottitis without obstruction
J05.11	Acute epiglottitis with obstruction
J06.0	Acute laryngopharyngitis
J06.9	Acute upper respiratory infection, unspecified
J20.8	Acute bronchitis due to other specified organisms
J20.9	Acute bronchitis, unspecified
J21.0	Acute bronchiolitis due to respiratory syncytial virus
J21.1	Acute bronchiolitis due to human metapneumovirus
J21.8	Acute bronchiolitis due to other specified organisms
J21.9	Acute bronchiolitis, unspecified
J31.0	Chronic rhinitis
J31.1	Chronic nasopharyngitis
J31.2	Chronic pharyngitis
J32.0	Chronic maxillary sinusitis
J32.1	Chronic frontal sinusitis
J32.2	Chronic ethmoidal sinusitis
J32.3	Chronic sphenoidal sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J32.9	Chronic sinusitis, unspecified
J33.0	Polyp of nasal cavity
J33.1	Polypoid sinus degeneration
J33.8	Other polyp of sinus
J33.9	Nasal polyp, unspecified
J34.2	Deviated nasal septum
J37.0	Chronic laryngitis
J37.1	Chronic laryngotracheitis
J38.00	Paralysis of vocal cords and larynx, unspecified
J38.01	Paralysis of vocal cords and larynx, unilateral
ICD-10 CODE	DESCRIPTION
J38.02	Paralysis of vocal cords and larynx, bilateral

ICD-10 CODE	DESCRIPTION
J38.1	Polyp of vocal cord and larynx
J38.2	Nodules of vocal cords
J38.3	Other diseases of vocal cords
J38.4	Edema of larynx
J38.5	Laryngeal spasm
J38.6	Stenosis of larynx
J38.7	Other diseases of larynx
J39.8	Other specified diseases of upper respiratory tract
J39.9	Disease of upper respiratory tract, unspecified
K09.8	Other cysts of oral region, not elsewhere classified
K09.9	Cyst of oral region, unspecified
K12.0	Recurrent oral aphthae
K12.1	Other forms of stomatitis
K12.2	Cellulitis and abscess of mouth
K12.30	Oral mucositis (ulcerative), unspecified
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.32	Oral mucositis (ulcerative) due to other drugs
K12.33	Oral mucositis (ulcerative) due to radiation
K12.39	Other oral mucositis (ulcerative)
K13.0	Diseases of lips
K13.1	Cheek and lip biting
K13.21	Leukoplakia of oral mucosa, including tongue
K13.22	Minimal keratinized residual ridge mucosa
K13.23	Excessive keratinized residual ridge mucosa
K13.24	Leukokeratosis nicotina palati
K13.29	Other disturbances of oral epithelium, including tongue
K13.3	Hairy leukoplakia
K13.4	Granuloma and granuloma-like lesions of oral mucosa
K13.5	Oral submucous fibrosis
K13.6	Irritative hyperplasia of oral mucosa
K13.70	Unspecified lesions of oral mucosa
K13.79	Other lesions of oral mucosa

ICD-10 CODE	DESCRIPTION
M26.50	Dentofacial functional abnormalities, unspecified
M26.51	Abnormal jaw closure
M26.52	Limited mandibular range of motion
M26.53	Deviation in opening and closing of the mandible
M26.54	Insufficient anterior guidance
M26.55	Centric occlusion maximum intercuspation discrepancy
M26.56	Non-working side interference
M26.57	Lack of posterior occlusal support
M26.59	Other dentofacial functional abnormalities
P29.38	Other persistent fetal circulation
Q00.0	Anencephaly
Q00.1	Craniorachischisis
Q00.2	Iniencephaly
Q01.0	Frontal encephalocele
Q01.1	Nasofrontal encephalocele
Q01.2	Occipital encephalocele
Q01.8	Encephalocele of other sites
Q01.9	Encephalocele, unspecified
Q02	Microcephaly
Q03.0	Malformations of aqueduct of Sylvius
Q03.1	Atresia of foramina of Magendie and Luschka
Q03.8	Other congenital hydrocephalus
Q03.9	Congenital hydrocephalus, unspecified
Q04.0	Congenital malformations of corpus callosum
Q04.1	Arhinencephaly
Q04.2	Holoprosencephaly
Q04.3	Other reduction deformities of brain
Q04.4	Septo-optic dysplasia of brain
Q04.5	Megalencephaly
Q04.6	Congenital cerebral cysts
Q04.8	Other specified congenital malformations of brain
Q04.9	Congenital malformation of brain, unspecified

ICD-10 CODE	DESCRIPTION
Q05.0	Cervical spina bifida with hydrocephalus
Q05.1	Thoracic spina bifida with hydrocephalus
Q05.2	Lumbar spina bifida with hydrocephalus
Q05.3	Sacral spina bifida with hydrocephalus
Q05.4	Unspecified spina bifida with hydrocephalus
Q05.5	Cervical spina bifida without hydrocephalus
Q05.6	Thoracic spina bifida without hydrocephalus
Q05.7	Lumbar spina bifida without hydrocephalus
Q05.8	Sacral spina bifida without hydrocephalus
Q05.9	Spina bifida, unspecified
Q06.0	Amyelia
Q06.1	Hypoplasia and dysplasia of spinal cord
Q06.2	Diastematomyelia
Q06.3	Other congenital cauda equina malformations
Q06.4	Hydromyelia
Q06.8	Other specified congenital malformations of spinal cord
Q06.9	Congenital malformation of spinal cord, unspecified
Q07.00	Arnold-Chiari syndrome without spina bifida or hydrocephalus
Q07.01	Arnold-Chiari syndrome with spina bifida
Q07.02	Arnold-Chiari syndrome with hydrocephalus
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus
Q07.8	Other specified congenital malformations of nervous system
Q07.9	Congenital malformation of nervous system, unspecified
Q10.0	Congenital ptosis
Q10.1	Congenital ectropion
Q10.2	Congenital entropion
Q10.3	Other congenital malformations of eyelid
Q10.4	Absence and agenesis of lacrimal apparatus
Q10.5	Congenital stenosis and stricture of lacrimal duct
Q10.6	Other congenital malformations of lacrimal apparatus
Q10.7	Congenital malformation of orbit
Q11.0	Cystic eyeball

ICD-10 CODE	DESCRIPTION
Q11.1	Other anophthalmos
Q11.2	Microphthalmos
Q11.3	Macrophthalmos
ICD-10 CODE	DESCRIPTION
Q12.0	Congenital cataract
Q12.1	Congenital displaced lens
Q12.2	Coloboma of lens
Q12.3	Congenital aphakia
Q12.4	Spherophakia
Q12.8	Other congenital lens malformations
Q12.9	Congenital lens malformation, unspecified
Q13.0	Coloboma of iris
Q13.1	Absence of iris
Q13.2	Other congenital malformations of iris
Q13.3	Congenital corneal opacity
Q13.4	Other congenital corneal malformations
Q13.5	Blue sclera
Q13.81	Rieger's anomaly
Q13.89	Other congenital malformations of anterior segment of eye
Q13.9	Congenital malformation of anterior segment of eye, unspecified
Q14.0	Congenital malformation of vitreous humor
Q14.1	Congenital malformation of retina
Q14.2	Congenital malformation of optic disc
Q14.3	Congenital malformation of choroid
Q14.8	Other congenital malformations of posterior segment of eye
Q14.9	Congenital malformation of posterior segment of eye, unspecified
Q15.0	Congenital glaucoma
Q15.8	Other specified congenital malformations of eye
Q15.9	Congenital malformation of eye, unspecified
Q16.0	Congenital absence of (ear) auricle
Q16.1	Congenital absence, atresia and stricture of auditory canal (external)
Q16.2	Absence of eustachian tube

ICD-10 CODE	DESCRIPTION
Q16.3	Congenital malformation of ear ossicles
Q16.4	Other congenital malformations of middle ear
Q16.5	Congenital malformation of inner ear
Q16.9	Congenital malformation of ear causing impairment of hearing, unspecified
Q17.0	Accessory auricle
Q17.1	Macrotia
Q17.2	Microtia
Q17.3	Other misshapen ear
Q17.4	Misplaced ear
Q17.5	Prominent ear
Q17.8	Other specified congenital malformations of ear
Q17.9	Congenital malformation of ear, unspecified
Q18.0	Sinus, fistula and cyst of branchial cleft
Q18.1	Preauricular sinus and cyst
Q18.2	Other branchial cleft malformations
Q18.3	Webbing of neck
Q18.4	Macrostomia
Q18.5	Microstomia
Q18.6	Macrocheilia
Q18.7	Microcheilia
Q18.8	Other specified congenital malformations of face and neck
Q18.9	Congenital malformation of face and neck, unspecified
Q20.0	Common arterial trunk
Q20.1	Double outlet right ventricle
Q20.2	Double outlet left ventricle
Q20.3	Discordant ventriculoarterial connection
Q20.4	Double inlet ventricle
Q20.5	Discordant atrioventricular connection
Q20.6	Isomerism of atrial appendages
Q20.8	Other congenital malformations of cardiac chambers and connections
Q20.9	Congenital malformation of cardiac chambers and connections, unspecified
Q21.0	Ventricular septal defect

ICD-10 CODE	DESCRIPTION
Q21.1	Atrial septal defect
Q21.2	Atrioventricular septal defect
Q21.3	Tetralogy of Fallot
Q21.4	Aortopulmonary septal defect
Q21.8	Other congenital malformations of cardiac septa
Q21.9	Congenital malformation of cardiac septum, unspecified
Q22.0	Pulmonary valve atresia
Q22.1	Congenital pulmonary valve stenosis
Q22.2	Congenital pulmonary valve insufficiency
Q22.3	Other congenital malformations of pulmonary valve
Q22.4	Congenital tricuspid stenosis
Q22.5	Ebstein's anomaly
Q22.6	Hypoplastic right heart syndrome
Q22.8	Other congenital malformations of tricuspid valve
Q22.9	Congenital malformation of tricuspid valve, unspecified
Q23.0	Congenital stenosis of aortic valve
Q23.1	Congenital insufficiency of aortic valve
Q23.2	Congenital mitral stenosis
Q23.3	Congenital mitral insufficiency
Q23.4	Hypoplastic left heart syndrome
Q23.8	Other congenital malformations of aortic and mitral valves
Q23.9	Congenital malformation of aortic and mitral valves, unspecified
Q24.0	Dextrocardia
Q24.1	Levocardia
Q24.2	Cor triatriatum
Q24.3	Pulmonary infundibular stenosis
Q24.4	Congenital subaortic stenosis
Q24.5	Malformation of coronary vessels
Q24.6	Congenital heart block
Q24.8	Other specified congenital malformations of heart
Q24.9	Congenital malformation of heart, unspecified
Q25.0	Patent ductus arteriosus

ICD-10 CODE	DESCRIPTION
Q25.1	Coarctation of aorta
Q25.3	Supravalvular aortic stenosis
Q25.5	Atresia of pulmonary artery
Q25.6	Stenosis of pulmonary artery
Q25.71	Coarctation of pulmonary artery
Q25.72	Congenital pulmonary arteriovenous malformation
Q25.79	Other congenital malformations of pulmonary artery
Q25.8	Other congenital malformations of other great arteries
ICD-10 CODE	DESCRIPTION
Q25.9	Congenital malformation of great arteries, unspecified
Q26.0	Congenital stenosis of vena cava
Q26.1	Persistent left superior vena cava
Q26.2	Total anomalous pulmonary venous connection
Q26.3	Partial anomalous pulmonary venous connection
Q26.4	Anomalous pulmonary venous connection, unspecified
Q26.5	Anomalous portal venous connection
Q26.6	Portal vein-hepatic artery fistula
Q26.8	Other congenital malformations of great veins
Q26.9	Congenital malformation of great vein, unspecified
Q27.0	Congenital absence and hypoplasia of umbilical artery
Q27.1	Congenital renal artery stenosis
Q27.2	Other congenital malformations of renal artery
Q27.30	Arteriovenous malformation, site unspecified
Q27.31	Arteriovenous malformation of vessel of upper limb
Q27.32	Arteriovenous malformation of vessel of lower limb
Q27.33	Arteriovenous malformation of digestive system vessel
Q27.34	Arteriovenous malformation of renal vessel
Q27.39	Arteriovenous malformation, other site
Q27.4	Congenital phlebectasia
Q27.8	Other specified congenital malformations of peripheral vascular system
Q27.9	Congenital malformation of peripheral vascular system, unspecified
Q28.0	Arteriovenous malformation of precerebral vessels

ICD-10 CODE	DESCRIPTION
Q28.1	Other malformations of precerebral vessels
Q28.2	Arteriovenous malformation of cerebral vessels
Q28.3	Other malformations of cerebral vessels
Q28.8	Other specified congenital malformations of circulatory system
Q28.9	Congenital malformation of circulatory system, unspecified
Q30.0	Choanal atresia
Q30.1	Agenesis and underdevelopment of nose
Q30.2	Fissured, notched and cleft nose
Q30.3	Congenital perforated nasal septum
Q30.8	Other congenital malformations of nose
Q30.9	Congenital malformation of nose, unspecified
Q31.0	Web of larynx
Q31.1	Congenital subglottic stenosis
Q31.2	Laryngeal hypoplasia
Q31.3	Laryngocele
Q31.5	Congenital laryngomalacia
Q31.8	Other congenital malformations of larynx
Q31.9	Congenital malformation of larynx, unspecified
Q32.0	Congenital tracheomalacia
Q32.1	Other congenital malformations of trachea
Q32.2	Congenital bronchomalacia
Q32.3	Congenital stenosis of bronchus
Q32.4	Other congenital malformations of bronchus
Q35.1	Cleft hard palate
Q35.3	Cleft soft palate
Q35.5	Cleft hard palate with cleft soft palate
Q35.7	Cleft uvula
Q35.9	Cleft palate, unspecified
Q36.9	Cleft lip, unilateral
Q37.9	Unspecified cleft palate with unilateral cleft lip
Q38.1	Ankyloglossia
Q38.2	Macroglossia

ICD-10 CODE	DESCRIPTION
Q38.3	Other congenital malformations of tongue
Q90.0	Trisomy 21, nonmosaicism (meiotic nondisjunction)
Q90.1	Trisomy 21, mosaicism (mitotic nondisjunction)
Q90.2	Trisomy 21, translocation
Q90.9	Down syndrome, unspecified
R41.4	Neurologic neglect syndrome
R41.841	Cognitive communication deficit
R47.01	Aphasia
R47.02	Dysphasia
R47.1	Dysarthria and anarthria
R47.81	Slurred speech
R47.82	Fluency disorder in conditions classified elsewhere
R47.89	Other speech disturbances
R47.9	Unspecified speech disturbances
R48.0	Dyslexia and alexia
R48.1	Agnosia
R48.2	Apraxia
R48.8	Other symbolic dysfunctions
R48.9	Unspecified symbolic dysfunctions
R49.0	Dysphonia
R49.1	Aphonia
R49.21	Hypernasality
R49.22	Hyponasality
R49.8	Other voice and resonance disorders
R49.9	Unspecified voice and resonance disorder
R62.0	Delayed milestone in childhood
S01.522A	Laceration with foreign body of oral cavity, initial encounter
S01.542A	Puncture wound with foreign body of oral cavity, initial encounter
S01.90XA	Unspecified open wound of unspecified part of head, initial encounter
S02.0XXS	Fracture of vault of skull, sequela
S02.101S	Fracture of base of skull, right side, sequela
S02.102S	Fracture of base of skull, left side, sequela

ICD-10 CODE	DESCRIPTION
S02.110S	Type I occipital condyle fracture, unspecified side, sequela
S02.111S	Type II occipital condyle fracture, unspecified side, sequela
S02.112S	Type III occipital condyle fracture, unspecified side, sequela
S02.113S	Unspecified occipital condyle fracture, sequela
S02.118S	Other fracture of occiput, unspecified side, sequela
S02.119S	Unspecified fracture of occiput, sequela
S02.19XS	Other fracture of base of skull, sequela
S02.2XXS	Fracture of nasal bones, sequela
S02.400S	Malar fracture, unspecified side, sequela
S02.401S	Maxillary fracture, unspecified side, sequela
S02.402S	Zygomatic fracture, unspecified side, sequela
S02.40AS	Malar fracture, right side, sequela
S02.40BS	Malar fracture, left side, sequela
ICD-10 CODE	DESCRIPTION
S02.40CS	Maxillary fracture, right side, sequela
S02.40DS	Maxillary fracture, left side, sequela
S02.411S	LeFort I fracture, sequela
S02.412S	LeFort II fracture, sequela
S02.413S	LeFort III fracture, sequela
S02.42XS	Fracture of alveolus of maxilla, sequela
S02.5XXA	Fracture of tooth (traumatic), initial encounter for closed fracture
S02.5XXB	Fracture of tooth (traumatic), initial encounter for open fracture
S02.5XXS	Fracture of tooth (traumatic), sequela
S02.600S	Fracture of unspecified part of body of mandible, unspecified side, sequela
S02.609S	Fracture of mandible, unspecified, sequela
S02.611S	Fracture of condylar process of right mandible, sequela
S02.612S	Fracture of condylar process of left mandible, sequela
S02.621S	Fracture of subcondylar process of right mandible, sequela
S02.622S	Fracture of subcondylar process of left mandible, sequela
S02.641S	Fracture of ramus of right mandible, sequela
S02.642S	Fracture of ramus of left mandible, sequela
S02.651S	Fracture of angle of right mandible, sequela

ICD-10 CODE	DESCRIPTION
S02.652S	Fracture of angle of left mandible, sequela
S02.66XS	Fracture of symphysis of mandible, sequela
S02.671S	Fracture of alveolus of right mandible, sequela
S02.672S	Fracture of alveolus of left mandible, sequela
S02.69XS	Fracture of mandible of other specified site, sequela
S02.91XS	Unspecified fracture of skull, sequela
S02.92XS	Unspecified fracture of facial bones, sequela
S04.011S	Injury of optic nerve, right eye, sequela
S04.012S	Injury of optic nerve, left eye, sequela
S04.019S	Injury of optic nerve, unspecified eye, sequela
S04.02XS	Injury of optic chiasm, sequela
S04.031S	Injury of optic tract and pathways, right side, sequela
S04.032S	Injury of optic tract and pathways, left side, sequela
S04.039S	Injury of optic tract and pathways, unspecified side, sequela
S04.041S	Injury of visual cortex, right side, sequela
S04.042S	Injury of visual cortex, left side, sequela
S04.049S	Injury of visual cortex, unspecified side, sequela
S04.10XS	Injury of oculomotor nerve, unspecified side, sequela
S04.11XS	Injury of oculomotor nerve, right side, sequela
S04.12XS	Injury of oculomotor nerve, left side, sequela
S04.20XS	Injury of trochlear nerve, unspecified side, sequela
S04.21XS	Injury of trochlear nerve, right side, sequela
S04.22XS	Injury of trochlear nerve, left side, sequela
S04.30XS	Injury of trigeminal nerve, unspecified side, sequela
S04.31XS	Injury of trigeminal nerve, right side, sequela
S04.32XS	Injury of trigeminal nerve, left side, sequela
S04.40XS	Injury of abducent nerve, unspecified side, sequela
S04.41XS	Injury of abducent nerve, right side, sequela
S04.42XS	Injury of abducent nerve, left side, sequela
S04.50XS	Injury of facial nerve, unspecified side, sequela
S04.51XS	Injury of facial nerve, right side, sequela
S04.52XS	Injury of facial nerve, left side, sequela

ICD-10 CODE	DESCRIPTION
S04.60XS	Injury of acoustic nerve, unspecified side, sequela
S04.61XS	Injury of acoustic nerve, right side, sequela
S04.62XS	Injury of acoustic nerve, left side, sequela
S04.70XS	Injury of accessory nerve, unspecified side, sequela
S04.71XS	Injury of accessory nerve, right side, sequela
S04.72XS	Injury of accessory nerve, left side, sequela
S04.811S	Injury of olfactory [1st] nerve, right side, sequela
S04.812S	Injury of olfactory [1st] nerve, left side, sequela
S04.819S	Injury of olfactory [1st] nerve, unspecified side, sequela
S04.891S	Injury of other cranial nerves, right side, sequela
S04.892S	Injury of other cranial nerves, left side, sequela
S04.899S	Injury of other cranial nerves, unspecified side, sequela
S04.9XXS	Injury of unspecified cranial nerve, sequela
S06.0X0A	Concussion without loss of consciousness, initial encounter
S06.0X0S	Concussion without loss of consciousness, sequela
S06.0X1A	Concussion with loss of consciousness of 30 minutes or less, initial encounter
S06.0X1S	Concussion with loss of consciousness of 30 minutes or less, sequela
S06.0X9A	Concussion with loss of consciousness of unspecified duration, initial encounter
S06.0X9S	Concussion with loss of consciousness of unspecified duration, sequela
S06.1X0A	Traumatic cerebral edema without loss of consciousness, initial encounter
S06.1X0S	Traumatic cerebral edema without loss of consciousness, sequela
S06.1X1A	Traumatic cerebral edema with loss of consciousness of 30 minutes or less, initial encounter
S06.1X1S	Traumatic cerebral edema with loss of consciousness of 30 minutes or less, sequela
S06.1X2A	Traumatic cerebral edema with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.1X2S	Traumatic cerebral edema with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.1X3A	Traumatic cerebral edema with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.1X3S	Traumatic cerebral edema with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.1X4A	Traumatic cerebral edema with loss of consciousness of 6 hours to 24 hours, initial

ICD-10 CODE	DESCRIPTION
	encounter
S06.1X4S	Traumatic cerebral edema with loss of consciousness of 6 hours to 24 hours, sequela
S06.1X5A	Traumatic cerebral edema with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.1X5S	Traumatic cerebral edema with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.1X6A	Traumatic cerebral edema with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.1X6S	Traumatic cerebral edema with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.1X9A	Traumatic cerebral edema with loss of consciousness of unspecified duration, initial encounter
S06.1X9S	Traumatic cerebral edema with loss of consciousness of unspecified duration, sequela
S06.2X0A	Diffuse traumatic brain injury without loss of consciousness, initial encounter
S06.2X0S	Diffuse traumatic brain injury without loss of consciousness, sequela
S06.2X1A	Diffuse traumatic brain injury with loss of consciousness of 30 minutes or less, initial encounter
S06.2X1S	Diffuse traumatic brain injury with loss of consciousness of 30 minutes or less, sequela
S06.2X2A	Diffuse traumatic brain injury with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.2X2S	Diffuse traumatic brain injury with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.2X3A	Diffuse traumatic brain injury with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.2X3S	Diffuse traumatic brain injury with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.2X4A	Diffuse traumatic brain injury with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.2X4S	Diffuse traumatic brain injury with loss of consciousness of 6 hours to 24 hours, sequela
S06.2X5A	Diffuse traumatic brain injury with loss of consciousness greater than 24 hours with return to pre-existing conscious levels, initial encounter
S06.2X5S	Diffuse traumatic brain injury with loss of consciousness greater than 24 hours with return to pre-existing conscious levels, sequela

ICD-10 CODE	DESCRIPTION
S06.2X6A	Diffuse traumatic brain injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.2X6S	Diffuse traumatic brain injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.2X9A	Diffuse traumatic brain injury with loss of consciousness of unspecified duration, initial encounter
ICD-10 CODE	DESCRIPTION
S06.2X9S	Diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela
S06.300A	Unspecified focal traumatic brain injury without loss of consciousness, initial encounter
S06.300S	Unspecified focal traumatic brain injury without loss of consciousness, sequela
S06.301A	Unspecified focal traumatic brain injury with loss of consciousness of 30 minutes or less, initial encounter
S06.301S	Unspecified focal traumatic brain injury with loss of consciousness of 30 minutes or less, sequela
S06.302A	Unspecified focal traumatic brain injury with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.302S	Unspecified focal traumatic brain injury with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.303A	Unspecified focal traumatic brain injury with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.303S	Unspecified focal traumatic brain injury with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.304A	Unspecified focal traumatic brain injury with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.304S	Unspecified focal traumatic brain injury with loss of consciousness of 6 hours to 24 hours, sequela
S06.305A	Unspecified focal traumatic brain injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.305S	Unspecified focal traumatic brain injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.306A	Unspecified focal traumatic brain injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.306S	Unspecified focal traumatic brain injury with loss of consciousness greater than 24

ICD-10 CODE	DESCRIPTION
	hours without return to pre-existing conscious level with patient surviving, sequela
S06.309A	Unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, initial encounter
S06.309S	Unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, sequela
S06.310A	Contusion and laceration of right cerebrum without loss of consciousness, initial encounter
S06.310S	Contusion and laceration of right cerebrum without loss of consciousness, sequela
S06.311A	Contusion and laceration of right cerebrum with loss of consciousness of 30 minutes or less, initial encounter
S06.311S	Contusion and laceration of right cerebrum with loss of consciousness of 30 minutes or less, sequela
S06.312A	Contusion and laceration of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.312S	Contusion and laceration of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.313A	Contusion and laceration of right cerebrum with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.313S	Contusion and laceration of right cerebrum with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.314A	Contusion and laceration of right cerebrum with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.314S	Contusion and laceration of right cerebrum with loss of consciousness of 6 hours to 24 hours, sequela
S06.315A	Contusion and laceration of right cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.315S	Contusion and laceration of right cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.316A	Contusion and laceration of right cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.316S	Contusion and laceration of right cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.319A	Contusion and laceration of right cerebrum with loss of consciousness of unspecified duration, initial encounter
S06.319S	Contusion and laceration of right cerebrum with loss of consciousness of unspecified

ICD-10 CODE	DESCRIPTION
	duration, sequela
S06.320A	Contusion and laceration of left cerebrum without loss of consciousness, initial encounter
S06.320S	Contusion and laceration of left cerebrum without loss of consciousness, sequela
S06.321A	Contusion and laceration of left cerebrum with loss of consciousness of 30 minutes or less, initial encounter
S06.321S	Contusion and laceration of left cerebrum with loss of consciousness of 30 minutes or less, sequela
S06.322A	Contusion and laceration of left cerebrum with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.322S	Contusion and laceration of left cerebrum with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.323A	Contusion and laceration of left cerebrum with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.323S	Contusion and laceration of left cerebrum with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.324A	Contusion and laceration of left cerebrum with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.324S	Contusion and laceration of left cerebrum with loss of consciousness of 6 hours to 24 hours, sequela
S06.325A	Contusion and laceration of left cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.325S	Contusion and laceration of left cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.326A	Contusion and laceration of left cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.326S	Contusion and laceration of left cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.329A	Contusion and laceration of left cerebrum with loss of consciousness of unspecified duration, initial encounter
S06.329S	Contusion and laceration of left cerebrum with loss of consciousness of unspecified duration, sequela
S06.330A	Contusion and laceration of cerebrum, unspecified, without loss of consciousness, initial encounter
S06.330S	Contusion and laceration of cerebrum, unspecified, without loss of consciousness, sequela

ICD-10 CODE	DESCRIPTION
S06.331A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, initial encounter
S06.331S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, sequela
S06.332A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.332S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.333A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.333S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.334A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.334S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 6 hours to 24 hours, sequela
S06.335A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.335S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.336A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.336S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.339A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of unspecified duration, initial encounter
S06.339S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of unspecified duration, sequela
S06.340S	Traumatic hemorrhage of right cerebrum without loss of consciousness, sequela
S06.341S	Traumatic hemorrhage of right cerebrum with loss of consciousness of 30 minutes or less, sequela
S06.342S	Traumatic hemorrhage of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.343S	Traumatic hemorrhage of right cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, sequela

ICD-10 CODE	DESCRIPTION
S06.344S	Traumatic hemorrhage of right cerebrum with loss of consciousness of 6 hours to 24 hours, sequela
S06.345S	Traumatic hemorrhage of right cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.346S	Traumatic hemorrhage of right cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.349S	Traumatic hemorrhage of right cerebrum with loss of consciousness of unspecified duration, sequela
S06.350S	Traumatic hemorrhage of left cerebrum without loss of consciousness, sequela
S06.351S	Traumatic hemorrhage of left cerebrum with loss of consciousness of 30 minutes or less, sequela
S06.352S	Traumatic hemorrhage of left cerebrum with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.353S	Traumatic hemorrhage of left cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, sequela
S06.354S	Traumatic hemorrhage of left cerebrum with loss of consciousness of 6 hours to 24 hours, sequela
S06.355S	Traumatic hemorrhage of left cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.356S	Traumatic hemorrhage of left cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.359S	Traumatic hemorrhage of left cerebrum with loss of consciousness of unspecified duration, sequela
S06.360S	Traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, sequela
S06.361S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, sequela
S06.362S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.363S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 1 hours to 5 hours 59 minutes, sequela
S06.364S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 6 hours to 24 hours, sequela
S06.365S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.366S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving,

ICD-10 CODE	DESCRIPTION
	sequela
S06.369S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of unspecified duration, sequela
S06.370A	Contusion, laceration, and hemorrhage of cerebellum without loss of consciousness, initial encounter
S06.370S	Contusion, laceration, and hemorrhage of cerebellum without loss of consciousness, sequela
S06.371A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 30 minutes or less, initial encounter
S06.371S	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 30 minutes or less, sequela
S06.372A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.372S	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.373A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.373S	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.374A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.374S	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 6 hours to 24 hours, sequela
S06.375A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
ICD-10 CODE	DESCRIPTION
S06.375S	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.376A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.376S	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.379A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of unspecified duration, initial encounter
S06.379S	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of

ICD-10 CODE	DESCRIPTION
	unspecified duration, sequela
S06.380A	Contusion, laceration, and hemorrhage of brainstem without loss of consciousness, initial encounter
S06.380S	Contusion, laceration, and hemorrhage of brainstem without loss of consciousness, sequela
S06.381A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 30 minutes or less, initial encounter
S06.381S	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 30 minutes or less, sequela
S06.382A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.382S	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.383A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.383S	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.384A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.384S	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 6 hours to 24 hours, sequela
S06.385A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.385S	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.386A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.386S	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.389A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of unspecified duration, initial encounter
S06.389S	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of unspecified duration, sequela
S06.4X0S	Epidural hemorrhage without loss of consciousness, sequela
S06.4X1S	Epidural hemorrhage with loss of consciousness of 30 minutes or less, sequela

ICD-10 CODE	DESCRIPTION
S06.4X2S	Epidural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.4X3S	Epidural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.4X4S	Epidural hemorrhage with loss of consciousness of 6 hours to 24 hours, sequela
S06.4X5S	Epidural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.4X6S	Epidural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.4X9S	Epidural hemorrhage with loss of consciousness of unspecified duration, sequela
S06.5X0S	Traumatic subdural hemorrhage without loss of consciousness, sequela
S06.5X1S	Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, sequela
S06.5X2S	Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.5X3S	Traumatic subdural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.5X4S	Traumatic subdural hemorrhage with loss of consciousness of 6 hours to 24 hours, sequela
S06.5X5S	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.5X6S	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.5X9S	Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, sequela
S06.6X0S	Traumatic subarachnoid hemorrhage without loss of consciousness, sequela
S06.6X1S	Traumatic subarachnoid hemorrhage with loss of consciousness of 30 minutes or less, sequela
S06.6X2S	Traumatic subarachnoid hemorrhage with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.6X3S	Traumatic subarachnoid hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.6X4S	Traumatic subarachnoid hemorrhage with loss of consciousness of 6 hours to 24 hours, sequela
S06.6X5S	Traumatic subarachnoid hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela

ICD-10 CODE	DESCRIPTION
S06.6X6S	Traumatic subarachnoid hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.6X9S	Traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, sequela
S06.810A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified without loss of consciousness, initial encounter
S06.810S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified without loss of consciousness, sequela
S06.811A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 30 minutes or less, initial encounter
S06.811S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 30 minutes or less, sequela
S06.812A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.812S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.813A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.813S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.814A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.814S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 6 hours to 24 hours, sequela
S06.815A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.815S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.816A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.816S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.819A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, initial encounter

ICD-10 CODE	DESCRIPTION
S06.819S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, sequela
S06.820A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified without loss of consciousness, initial encounter
S06.820S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified without loss of consciousness, sequela
S06.821A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 30 minutes or less, initial encounter
S06.821S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 30 minutes or less, sequela
S06.822A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.822S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.823A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.823S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.824A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.824S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 6 hours to 24 hours, sequela
S06.825A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.825S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.826A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.826S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.829A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, initial encounter
S06.829S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, sequela

ICD-10 CODE	DESCRIPTION
S06.890A	Other specified intracranial injury without loss of consciousness, initial encounter
S06.890S	Other specified intracranial injury without loss of consciousness, sequela
S06.891A	Other specified intracranial injury with loss of consciousness of 30 minutes or less, initial encounter
S06.891S	Other specified intracranial injury with loss of consciousness of 30 minutes or less, sequela
S06.892A	Other specified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.892S	Other specified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.893A	Other specified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.893S	Other specified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.894A	Other specified intracranial injury with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.894S	Other specified intracranial injury with loss of consciousness of 6 hours to 24 hours, sequela
S06.895A	Other specified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.895S	Other specified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.896A	Other specified intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.896S	Other specified intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.899A	Other specified intracranial injury with loss of consciousness of unspecified duration, initial encounter
S06.899S	Other specified intracranial injury with loss of consciousness of unspecified duration, sequela
S06.9X0A	Unspecified intracranial injury without loss of consciousness, initial encounter
S06.9X0S	Unspecified intracranial injury without loss of consciousness, sequela
S06.9X1A	Unspecified intracranial injury with loss of consciousness of 30 minutes or less, initial encounter
S06.9X1S	Unspecified intracranial injury with loss of consciousness of 30 minutes or less, sequela

ICD-10 CODE	DESCRIPTION
S06.9X2A	Unspecified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.9X2S	Unspecified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.9X3A	Unspecified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
ICD-10 CODE	DESCRIPTION
S06.9X3S	Unspecified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.9X4A	Unspecified intracranial injury with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.9X4S	Unspecified intracranial injury with loss of consciousness of 6 hours to 24 hours, sequela
S06.9X5A	Unspecified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.9X5S	Unspecified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.9X6A	Unspecified intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.9X6S	Unspecified intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.9X9A	Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter
S06.9X9S	Unspecified intracranial injury with loss of consciousness of unspecified duration, sequela
S09.0XXS	Injury of blood vessels of head, not elsewhere classified, sequela
S11.012A	Laceration with foreign body of larynx, initial encounter
S11.014A	Puncture wound with foreign body of larynx, initial encounter
S11.022A	Laceration with foreign body of trachea, initial encounter
S11.024A	Puncture wound with foreign body of trachea, initial encounter
S11.032A	Laceration with foreign body of vocal cord, initial encounter
S11.034A	Puncture wound with foreign body of vocal cord, initial encounter
S11.22XA	Laceration with foreign body of pharynx and cervical esophagus, initial encounter
S11.24XA	Puncture wound with foreign body of pharynx and cervical esophagus, initial encounter

ICD-10 CODE	DESCRIPTION
S15.001S	Unspecified injury of right carotid artery, sequela
S15.002S	Unspecified injury of left carotid artery, sequela
S15.009S	Unspecified injury of unspecified carotid artery, sequela
S15.011S	Minor laceration of right carotid artery, sequela
S15.012S	Minor laceration of left carotid artery, sequela
S15.019S	Minor laceration of unspecified carotid artery, sequela
S15.021S	Major laceration of right carotid artery, sequela
S15.022S	Major laceration of left carotid artery, sequela
S15.029S	Major laceration of unspecified carotid artery, sequela
S15.091S	Other specified injury of right carotid artery, sequela
S15.092S	Other specified injury of left carotid artery, sequela
S15.099S	Other specified injury of unspecified carotid artery, sequela
S15.101S	Unspecified injury of right vertebral artery, sequela
S15.102S	Unspecified injury of left vertebral artery, sequela
S15.109S	Unspecified injury of unspecified vertebral artery, sequela
S15.111S	Minor laceration of right vertebral artery, sequela
S15.112S	Minor laceration of left vertebral artery, sequela
S15.119S	Minor laceration of unspecified vertebral artery, sequela
S15.121S	Major laceration of right vertebral artery, sequela
S15.122S	Major laceration of left vertebral artery, sequela
S15.129S	Major laceration of unspecified vertebral artery, sequela
S15.191S	Other specified injury of right vertebral artery, sequela
S15.192S	Other specified injury of left vertebral artery, sequela
S15.199S	Other specified injury of unspecified vertebral artery, sequela
S15.201S	Unspecified injury of right external jugular vein, sequela
S15.202S	Unspecified injury of left external jugular vein, sequela
S15.209S	Unspecified injury of unspecified external jugular vein, sequela
S15.211S	Minor laceration of right external jugular vein, sequela
S15.212S	Minor laceration of left external jugular vein, sequela
S15.219S	Minor laceration of unspecified external jugular vein, sequela
S15.221S	Major laceration of right external jugular vein, sequela
S15.222S	Major laceration of left external jugular vein, sequela

ICD-10 CODE	DESCRIPTION
S15.229S	Major laceration of unspecified external jugular vein, sequela
S15.291S	Other specified injury of right external jugular vein, sequela
S15.292S	Other specified injury of left external jugular vein, sequela
S15.299S	Other specified injury of unspecified external jugular vein, sequela
S15.301S	Unspecified injury of right internal jugular vein, sequela
S15.302S	Unspecified injury of left internal jugular vein, sequela
S15.309S	Unspecified injury of unspecified internal jugular vein, sequela
S15.311S	Minor laceration of right internal jugular vein, sequela
S15.312S	Minor laceration of left internal jugular vein, sequela
S15.319S	Minor laceration of unspecified internal jugular vein, sequela
S15.321S	Major laceration of right internal jugular vein, sequela
S15.322S	Major laceration of left internal jugular vein, sequela
S15.329S	Major laceration of unspecified internal jugular vein, sequela
S15.391S	Other specified injury of right internal jugular vein, sequela
S15.392S	Other specified injury of left internal jugular vein, sequela
S15.399S	Other specified injury of unspecified internal jugular vein, sequela
S15.8XXS	Injury of other specified blood vessels at neck level, sequela
S15.9XXS	Injury of unspecified blood vessel at neck level, sequela
T85.810S	Embolism due to nervous system prosthetic devices, implants and grafts, sequela
T85.818S	Embolism due to other internal prosthetic devices, implants and grafts, sequela
T85.830S	Hemorrhage due to nervous system prosthetic devices, implants and grafts, sequela
T85.838S	Hemorrhage due to other internal prosthetic devices, implants and grafts, sequela
T85.860S	Thrombosis due to nervous system prosthetic devices, implants and grafts, sequela
T85.868S	Thrombosis due to other internal prosthetic devices, implants and grafts, sequela
Z44.8	Encounter for fitting and adjustment of other external prosthetic devices
Z51.89	Encounter for other specified aftercare
Z85.21	Personal history of malignant neoplasm of larynx
Z85.841	Personal history of malignant neoplasm of brain
Z86.59	Personal history of other mental and behavioral disorders
Z96.3	Presence of artificial larynx
Z97.4	Presence of external hearing-aid

Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation:

*** Use additional diagnosis code(s) to clarify the reason/diagnosis for SLP services.**

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

All those not listed under the "ICD-10 Codes that Support Medical Necessity" section of this policy.

Group 1 Codes: N/A

Additional ICD-10 Information

N/A

General Information

Associated Information

Refer to Local Coverage Article, A54111, Speech Language Pathology (SLP) Services: Communication Disorders for additional information regarding proper billing and coding.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record should support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code should describe the service performed.
4. The medical record documentation must support the medical necessity of the services as directed in this policy.
5. Documentation of speech-language pathology services includes any entry into a patient's medical record such as a consultation report, initial examination report, patient informed consent notation, progress note, flow sheet/checklist that identifies the care/service that was provided, reexamination report or summation of care.
6. The medical record must identify the physician or non-physician practitioner responsible for the general medical care of the patient and the dates and outcomes of the clinical visits to this provider for continued evaluation during the course of therapy.
7. Refer to the "Coverage Indications, Limitations, and/or Medical Necessity" section of this policy for additional guidelines pertaining to the documentation requirements for the individual treatments/modalities.
8. Services will be denied if the medical record does not clearly indicate that the service that was billed was performed as per the CPT description, Indications and Limitations noted in this policy, the guidelines noted in the Documentation Requirements section of this policy and as per community standards of practice. Procedure codes that require supervision or time documentation will be denied if the medical record does not clearly support these services as billed.

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

Sources of Information

Contractor is not responsible for the continued viability of websites listed.

American Speech-Language Hearing Association. (2001). Guidelines for Medicare coverage of speech-language pathology services.

DynCorp Therapy PSC Protocol

Guide to Physical Therapist Practice

Other Contractor Policies

Contractor Medical Directors

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
03/29/2018	R8	LCD revised and published on 3/29/2018 to add clarifying language pertaining to rehabilitative and maintenance therapy from the CMS IOMs. Per LCD annual review, in the "CMS National Coverage Policy" section updated the IOM citations, removed Change Request references that contain information that is now in the CMS IOMs, and added additional relevant references. In the "History/Background" section, removed CPT code 96125 from the reference to LCD L35101 Psychiatric Codes because CPT code 96125 is no longer in that LCD. In the "Covered Indications" section, replaced references to CR #5921 with the applicable CMS IOM references. In the "CPT/HCPCS codes" section, removed CPT/HCPCS codes from the Group 1 codes that do not have diagnosis limitations at this time. In the "ICD-10 Codes that Support Medical Necessity" group 1 paragraph note, added reference to LCD L35101 (which also contains coverage for the CPT codes 96105 and 96111). Updated the LCD formatting throughout the LCD without a	• Other (Inquiry, Annual Review)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		change in coverage. Added hyperlinks in the "Associated Documents" section to related LCDs (L35101 Psychiatric Codes and L34891 Speech-Language Pathology (SLP) Services: Dysphagia, Includes VitalStim® Therapy) and related article (A54111 Speech Language Pathology (SLP) Services: Communication Disorders). At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; therefore, not all the fields included on the LCD are applicable as noted in this policy.	
01/01/2018	R7	LCD revised and published on 01/25/2018 effective for dates of service on and after 01/01/2018 to reflect the annual CPT/HCPCS code updates. The following CPT/HCPCS code has been deleted and therefore removed from group 1 of the LCD: 97532. The following CPT/HCPCS code has been added to group 1 of the LCD: G0515. The text in the policy has been updated to reflect the 2018 CPT/HCPCS Updates. At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; therefore, not all the fields included on the LCD are applicable as noted in this policy.	• Revisions Due To CPT/HCPCS Code Changes
10/01/2017	R6	LCD revised and published on 10/05/2017 effective for dates of service on and after 10/01/2017 to reflect the ICD-10 Annual Code Updates. The following ICD-10 code(s) have undergone a descriptor change: S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S. The following ICD-10 code(s) have been deleted from Group 1 codes: P29.3, S06.2X7S, S06.2X8S. The following ICD-10 code(s) have been added to Group 1 codes: G12.25, P29.38. At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; therefore, not all the fields included on the LCD are applicable as noted in this policy.	• Revisions Due To ICD-10-CM Code Changes
01/25/2017	R5	LCD revised and published on 04/13/2017 effective for dates of service on and after 01/25/2017 to remove asterisks from the following I-series ICD-10 diagnosis codes listed in Group	• Other (Inquiry)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		1: I69.010, I69.011, I69.013, I69.014, I69.018, I69.110, I69.111, I69.113, I69.114, I69.118, I69.210, I69.211, I69.213, I69.214, I69.218, I69.310, I69.311, I69.313, I69.314, I69.318, I69.810, I69.811, I69.813, I69.814, I69.818, I69.910, I69.911, I69.913, I69.914, I69.918.	
10/01/2016	R4	LCD revised and published on 09/29/2016 effective for dates of service on and after 10/01/2016 to reflect the ICD-10 Annual Code Updates. The following ICD-10 code(s) have been added: H90.A11, H90.A12, H90.A21, H90.A22, H90.A31, H90.A32, I69.010, I69.011, I69.013, I69.014, I69.018, I69.110, I69.111, I69.113, I69.114, I69.118, I69.210, I69.211, I69.213, I69.214, I69.218, I69.310, I69.311, I69.313, I69.314, I69.318, I69.810 , I69.811, I69.813, I69.814, I69.818, I69.910, I69.911, I69.913, I69.914, I69.918, S02.101S, S02.102S, S02.40AS, S02.40BS, S02.40CS, S02.40DS, S02.611S, S02.612S, S02.621S, S02.622S, S02.641S, S02.642S, S02.651S, S02.652S, S02.671S, S02.672S, T85.810S, T85.818S, T85.830S, T85.838S, T85.860S, and T85.868S. The following ICD-10 code(s) have been deleted and therefore, removed from the LCD: I69.01, I69.11, I69.21, I69.31, I69.81 , I69.91 , Q25.2, Q25.4, S02.10XS, S02.3XXS, S02.61XS, S02.62XS, S02.63XS, S02.64XS, S02.65XS, S02.67XS, S02.8XXS, S06.0X2A , S06.0X2S , S06.0X3A, S06.0X3S, S06.0X4A, S06.0X4S , S06.0X5A, S06.0X5S , S06.0X6A, S06.0X6S, T85.81XA, T85.82XA, T85.83XA, T85.84XA, T85.85XA, T85.86XA, and T85.89XA. The following ICD-10 code(s) have undergone a descriptor change: S02.110S, S02.111S, S02.112S, S02.118S, S02.400S, S02.401S, S02.402S, and S02.600S.	• Revisions Due To ICD-10-CM Code Changes
10/01/2015	R3	LCD revised and published on 04/14/2016 to include reference to Local Coverage Determinations, L35036-Therapy and Rehabilitation Services (PT, OT) and L35101-Psychiatric Codes.	• Provider Education/Guidance
10/01/2015	R2	LCD revised to include reference to Local Coverage Article, A54111, Speech Language Pathology (SLP) Services: Communication Disorders. LCD revised to create uniform LCD with other MAC jurisdiction.	• Provider Education/Guidance • Creation of Uniform LCDs With Other MAC Jurisdiction
10/01/2015	R1	LCD updated and published on 01/23/15 to reflect the annual CPT/HCPCS code updates. Either the short description and/or the long description was changed for CPT code *96110*.	• Revisions Due To CPT/HCPCS Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		Depending on which description is used in this LCD, there may not be any change in how the code displays in the document.	

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)
A54111 - Speech Language Pathology (SLP) Services: Communication Disorders
LCD(s)
L35101 - Psychiatric Codes
L34891 - Speech-Language Pathology (SLP) Services: Dysphagia; Includes VitalStim® Therapy
L35036 - Therapy and Rehabilitation Services (PT, OT)

Related National Coverage Documents

N/A

Public Version(s)

Updated on 03/23/2018 with effective dates 03/29/2018 - N/A
Updated on 01/19/2018 with effective dates 01/01/2018 - 03/28/2018
Updated on 09/29/2017 with effective dates 10/01/2017 - 12/31/2017
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

Keywords

N/A