DoD/VA WOUNDED, ILL, AND INJURED
SENIOR OVERSIGHT COMMITTEE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301

The Honorable Daniel K. Akaka
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed interim report responds to Section 1664 of the National Defense Authorization Act for Fiscal Year 2008, which requires the Secretary of Defense and the Secretary of Veterans Affairs to develop a joint report to Congress. The report is to describe the efforts of the Departments of Defense and Veterans Affairs to ensure those who sustain a traumatic brain injury (TBI) receive a medical designation concomitant with their injuries.

The Departments of Defense and Veterans Affairs are working to establish a cohesive and integrated approach to TBI that focuses on individual Service members, veterans, and their families. Our Departments are collaborating with the international medical community to update the International Classification of Disease, Ninth Revision, Clinical Modifications, to reflect the breakout of TBI into mild, moderate, and severe categorizations. The coding change proposal is in the final phases of development. We will submit the proposal to the National Center for Health Statistics (NCHS) in September 2008 for consideration at the NCHS meeting scheduled for December 2008. After we receive approval of the coding change, we will submit a final report to Congress by March 2009.

Thank you for your continued support of the Military Health System.

P. W. Dunne
Co-Chair, VA
Wounded, Ill and Injured
Overarching Integrated Product Team

Michael L. Dominguez
Co-Chair, DoD
Wounded, Ill and Injured
Overarching Integrated Product Team

Enclosure:
As stated

DoD/VA WOUNDED, ILL, AND INJURED
SENIOR OVERSIGHT COMMITTEE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301

The Honorable Bob Filner
Chairman
Committee on Veterans' Affairs
U. S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed interim report responds to Section 1664 of the National Defense Authorization Act for Fiscal Year 2008, which requires the Secretary of Defense and the Secretary of Veterans Affairs to develop a joint report to Congress. The report is to describe the efforts of the Departments of Defense and Veterans Affairs to ensure those who sustain a traumatic brain injury (TBI) receive a medical designation concomitant with their injuries.

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As stated

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SENIOR OVERSIGHT COMMITTEE
4000 DEFENSE PENTAGON
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The Honorable Carl Levin
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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SENIOR OVERSIGHT COMMITTEE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301

The Honorable Ike Skelton
Chairman
Committee on Armed Services
U. S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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SENIOR OVERSIGHT COMMITTEE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301

The Honorable Richard M. Burr
Ranking Member
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Senator Burr:

The enclosed interim report responds to Section 1664 of the National Defense Authorization Act for Fiscal Year 2008, which requires the Secretary of Defense and the Secretary of Veterans Affairs to develop a joint report to Congress. The report is to describe the efforts of the Departments of Defense and Veterans Affairs to ensure those who sustain a traumatic brain injury (TBI) receive a medical designation concomitant with their injuries.

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As stated

DoD/VA WOUNDED, ILL, AND INJURED
SENIOR OVERSIGHT COMMITTEE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301

The Honorable Steve Buyer
Ranking Republican Member
Committee on Veterans' Affairs
U. S. House of Representatives
Washington, DC 20515

Dear Congressman Buyer:

The enclosed interim report responds to Section 1664 of the National Defense Authorization Act for Fiscal Year 2008, which requires the Secretary of Defense and the Secretary of Veterans Affairs to develop a joint report to Congress. The report is to describe the efforts of the Departments of Defense and Veterans Affairs to ensure those who sustain a traumatic brain injury (TBI) receive a medical designation concomitant with their injuries.

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Enclosure:
As stated

DoD/VA WOUNDED, ILL, AND INJURED
SENIOR OVERSIGHT COMMITTEE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301

The Honorable Duncan Hunter
Ranking Member
Committee on Armed Services
U. S. House of Representatives
Washington, DC 20515

Dear Congressman Hunter:

The enclosed interim report responds to Section 1664 of the National Defense Authorization Act for Fiscal Year 2008, which requires the Secretary of Defense and the Secretary of Veterans Affairs to develop a joint report to Congress. The report is to describe the efforts of the Departments of Defense and Veterans Affairs to ensure those who sustain a traumatic brain injury (TBI) receive a medical designation concomitant with their injuries.

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Enclosure:
As stated

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SENIOR OVERSIGHT COMMITTEE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301

The Honorable John McCain
Ranking Member
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Senator McCain:

The enclosed interim report responds to Section 1664 of the National Defense Authorization Act for Fiscal Year 2008, which requires the Secretary of Defense and the Secretary of Veterans Affairs to develop a joint report to Congress. The report is to describe the efforts of the Departments of Defense and Veterans Affairs to ensure those who sustain a traumatic brain injury (TBI) receive a medical designation concomitant with their injuries.

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Enclosure:
As stated

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 1 3 2009

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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In August 2008, DoD and VA submitted a comprehensive, six-part TBI ICD-9-CM coding revision proposal to the National Center for Health Statistics (NCHS), and, in September 2008, presented the proposal to the ICD-9-CM Coordination and Maintenance Committee, an advisory committee that reviews all proposals and makes recommendations for modification to the NCHS. The proposal drew a number of comments from the Centers for Disease Control and Prevention National Center for Injury Prevention and Control (CDC/NCIPC), coding experts, and medical societies. A public comment period followed the meeting until December 5, 2008. The NCHS hosted a consensus meeting on December 15, 2008, with DoD, VA, the American Academy of Neurology, and the American Psychiatric Association to review the public comments and discuss outstanding issues. The meeting resulted in an agreement on all proposals except for concussion codes.

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The ICD-9-CM Coordination and Maintenance Committee will meet on March 12, 2009, after which NCHS has final approval authority for any changes to the ICD-9-CM code set. Approvals of proposals from the September 2008 and March 2009 meetings will be implemented in the October 1, 2009, edition of the ICD-9-CM. Any changes to ICD-9-CM also will link to ICD-10-CM, the next generation of disease classification codes due for U.S. implementation by 2013.

In the absence of the appropriate ICD-9 codes, as an interim solution, the military Services have implemented the Consensus Group's recommendations for the use of non-billable Extender Codes, or "V-codes," to help classify TBI for surveillance, stakeholder reporting requirements, and program planning. Universal training on the use of extender codes for clinical providers and other medical personnel is ongoing.

DoD and VA have made significant progress to ensure that Service members with TBI injuries receive a medical designation concomitant with their injury rather than a medical designation that assigns a generic classification. We continue to work with the international medical community, and anticipate approval of a new ICD-9-CM code this year. We will provide a final report to Congress on establishing the ICD-9-CM code for TBI after the new code has been published in October 2009.

Thank you for your continued support of the Military and Veterans Health Systems.

Sincerely,

S. Ward Casscells, MD

cc:
The Honorable John McCain
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 1 3 2009

The Honorable Ben Nelson
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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Sincerely,

S. Ward Casscells, MD

cc:
The Honorable Lindsey O. Graham
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 1 3 2009

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Thank you for your continued support of the Military and Veterans Health Systems.

Sincerely,

S. Ward Casscells, MD

cc:
The Honorable John M. McHugh
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 1 3 2009

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

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cc:
The Honorable Joe Wilson
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 1 3 2009

The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

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Sincerely,

S. Ward Casscells, MD

cc:
The Honorable Thad Cochran
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 1 3 2009

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Thank you for your continued support of the Military and Veterans Health Systems.

Sincerely,

S. Ward Casscells, MD

cc:
The Honorable Jerry Lewis
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 1 3 2009

The Honorable Daniel K. Akaka
Chairman, Committee on Veterans Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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Thank you for your continued support of the Military and Veterans Health Systems.

Sincerely,

S. Ward Casscells, MD

cc:
The Honorable Richard Burr
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 1 3 2009

The Honorable Bob Filner
Chairman, Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Thank you for your continued support of the Military and Veterans Health Systems.

Sincerely,

S. Ward Casscells, MD

cc:
The Honorable Steve Buyer
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 1 3 2009

The Honorable John J. Hall
Chairman, Subcommittee on Disability Assistance and Memorial Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Section 1664 of the National Defense Authorization Act for Fiscal Year 2008 required the Secretaries of Defense and Veterans Affairs to submit a report describing the changes undertaken within our Departments to ensure that Service members and veterans with traumatic brain injury (TBI) receive a medical designation concomitant with their injuries. In July 2008, we submitted an interim report describing the actions underway with the intent to provide a final report in January 2009. However, a major action—establishing an International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code for TBI—is not complete. Therefore, this is a second interim report describing our actions and the anticipated timeline to complete actions to establish the ICD-9-CM code for TBI.

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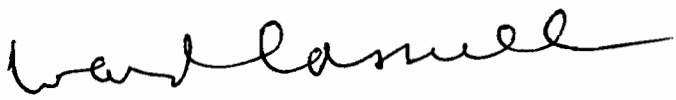
Thank you for your continued support of the Military and Veterans Health Systems.

Sincerely,



S. Ward Casscells, MD

cc:
The Honorable Doug Lamborn
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 1 3 2009

The Honorable Stephanie Herseth Sandlin
Subcommittee on Economic Opportunity
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

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Sincerely,

S. Ward Casscells, MD

cc:
The Honorable John Boozman
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 1 3 2009

The Honorable Michael H. Michaud
Chairman, Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Thank you for your continued support of the Military and Veterans Health Systems.

Sincerely,

S. Ward Casscells, MD

cc:
The Honorable Jerry Moran
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 1 3 2009

The Honorable Harry E. Mitchell
Subcommittee on Oversight and Investigations
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Thank you for your continued support of the Military and Veterans Health Systems.

Sincerely,

S. Ward Casscells, MD

cc:
The Honorable Brian P. Bilbray
Ranking Member (Acting)

Interim Report to Congress in Response to the National Defense Authorization Act for Fiscal Year 2008, Section 1664

Traumatic Brain Injury Classifications

TABLE OF CONTENTS

Interim Report on Traumatic Brain Injury Classifications

Introduction

The nature of the current conflict has brought traumatic brain injury (TBI) to the attention of all Americans and has compelled civilian and military leaders to take action. Focused on individual Service members, veterans, and their families, the Department of Defense (DoD), in partnership with the Department of Veterans Affairs (VA), is establishing a cohesive and integrated approach to TBI. From this close linkage, several initiatives have emerged that enhance our ability to provide world-class care for the ill and injured, implement process improvements, and advance our understanding of TBI.

DoD and VA Traumatic Brain Injury Focused Initiatives

- Jointly developing common clear definitions and terminology related to TBI to help advance our understanding of the natural history of the injury and improve prevention, identification, treatment, and rehabilitation;
- Identifying the injured through screening that uses appropriate tools to ensure every injured Service member and veteran receives the care he/she needs;
- Developing standardized training of all providers and staff based on the best available clinical guidance;
- Creating an integrated system to monitor TBI and collect data across the Military Health System and Veterans Health Administration to ensure quality care, identify potential research areas, and improve clinical outcomes; and
- Developing joint Clinical Practice Guidelines for the evaluation and treatment of mild TBI.

Traumatic Brain Injury Definition and Reporting

On October 1, 2007, the Assistant Secretary of Defense for Health Affairs signed a memorandum, "Traumatic Brain Injury: Definition and Reporting" (Appendix A), which established a uniform definition of mild, moderate, and severe TBI; a stratification of brain injury severity; and a method of data collection. The definitions of mild, moderate, and severe TBI were developed as a collaborative effort between the DoD and VA during the preceding 18 months. This policy is critical to addressing the persistent problem of under reporting of mild TBI and understanding its short- and long-term consequences.

DoD's most reliable data on the incidence of moderate and severe TBI, coming from the wars in Iraq and Afghanistan, reside at the Defense Veterans Brain Injury

Center (DVBIC), now a component of the Department of Defense Center of Excellence for Psychological Health and Traumatic Brain Injury. In the past, the DVBIC database has not been able to capture consistently data that occurred outside of the war zone or data related to mild TBI. Mild TBI has emerged as a focus in light of the concern for possible persistent physical, cognitive, and or psychological disability. To capture more accurate data, the Assistant Secretary of Defense for Health Affairs, on October 1, 2007, issued a memorandum requiring all Services to submit monthly reports that include demographic data enabling the DVBIC to collect accurate data for DoD.

The new reporting requirement provides the Assistant Secretary of Defense for Health Affairs a mechanism for surveillance and evaluation of aggregate data on all forms of TBI, which will provide more meaningful epidemiologic assessments. For the first time, this will include a 100 percent reporting of mild TBI, as well as the less prevalent moderate and severe injuries. In the past, this breadth of data was inconsistently available.

Diagnostic Classifications Revision

Knowledge of the number of Service members and veterans specifically diagnosed with TBI, as well as their health care and treatment outcomes, is critical to program development and resource planning, as DoD and the VA implement recommendations from Congress, Task Forces, and Commissions. The requirement to report reliable data to stakeholders is hindered by shortcomings in the existing TBI International Classification for Disease coding structure. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9 CM) is published by the World Health Organization and is the official system of assigning codes to diagnoses and procedures. ICD-9-CM is used globally for morbidity and mortality statistics, reimbursement systems, and automated decision support in medicine. This coding system is designed to promote international comparability in collecting, processing, classifying, and presenting disease statistics. The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) are the designated United States agencies responsible for overseeing all changes and modifications to the ICD-9-CM.

The current coding classifications have prevented the adequate characterization of the spectrum of TBI injury and its symptomatic manifestations. The larger medical community has been aware of this problem for some time and the DoD and VA clinical and coding communities have aligned to form a Consensus Group to develop a consolidated proposal for revising the ICD-9 CM codes for TBI.

The Consensus Group developed a coding revision proposal to submit to the NCHS and the CMS Coordination and Maintenance Committee. This committee is responsible for oversight of all changes and modifications to the ICD-9-CM. The committee functions solely in an advisory capacity, with all final decisions made by the

Director of NCHS and the Administrator of CMS after the annual December committee meeting. The submission timelines are pre-determined by the NCHS and CMS Coordination and Maintenance Committee and occur on an annual basis after a rigorous review and evaluation process. Our plan is to submit our coding proposal to the NCMS in September 2008 and, after receiving approvals, we expect to implement the new coding by October 2009.

Extender Codes

In the absence of the appropriate ICD-9-CM codes, as an interim solution, the Services have implemented the Consensus Group's recommendations for the use of non-billable Extender Codes, or 'V-codes', to help classify TBI for surveillance, stakeholder reporting requirements and program planning. Universal training on the use of extender codes for clinical providers and other medical personnel is ongoing. Coincident with provider training, and to enhance their use, AHLTA, DoD's electronic health record, added TBI extender codes to the electronic medical record.

Summary

DoD and VA have made significant progress to ensure that traumatic brain injury victims receive a medical designation concomitant with their injury rather than a medical designation that assigns a generic classification. Work with the international community continues and the subsequent approval of an improved ICD-9-CM TBI coding structure will represent a significant advancement.

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

OCT 1 2007

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (M&RA)

SUBJECT: Traumatic Brain Injury: Definition and Reporting

Reference: (a) Health Affairs Memorandum, "Consolidation of Traumatic Brain Injury Initiatives in the Department of Defense," dated March 23, 2007

Traumatic brain injury (TBI), whether mild, moderate, severe, or penetrating, is a significant health concern for the Department of Defense (DoD). To ensure a common understanding—as well as to design coordinated, coherent, high quality, and patient-centered programs—we must properly identify, document, and report those Service members who have suffered a TBI.

This memorandum establishes a common definition of TBI, severity of brain injury stratification, and method of data collection. These measures represent a major step toward unified TBI diagnosis and will lead to the advancement of therapeutic methods.

Services will identify TBI cases using the DoD definition of TBI (Attachment 1). Until automated mechanisms are established, Services will report all identified cases of TBI in accordance with Attachment 2. This requirement will become effective 60 days from the date of this memorandum. The Defense and Veterans Brain Injury Center (DVBIC) is designated as the single office of responsibility for the consolidation of all TBI-related incidence and prevalence information for DoD. The DVBIC will forward a monthly report (inclusive of Protected Health Information) to the office of the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness.

The DoD's management of Service members with TBI is evolving rapidly. Definition and reporting are the foundation upon which this program must be based. Services can anticipate incremental policies and guidance addressing other components

of TBI management such as training, coding (International Classification of Diseases-9), evaluation and treatment. These efforts will culminate in a new DoD Center of Excellence for TBI and Psychological Health.

S. Ward Casscells, MD

Attachments:
As stated

cc:
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force
Medical Officer of the Marine Corps
Joint Staff Surgeon
Defense Health Board

DEFINITION OF TRAUMATIC BRAIN INJURY

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

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

External forces may include any of the following events: the head being struck by an object, the head striking an object, the brain undergoing an acceleration/deceleration movement without direct external trauma to the head, a foreign body penetrating the brain, forces generated from events such as a blast or explosion, or other force yet to be defined.

The above criteria define the event of a traumatic brain injury (TBI). Sequelae of TBI may resolve quickly, within minutes to hours after the neurological event, or they may persist longer. Some sequelae of TBI may be permanent. Most signs and symptoms will manifest immediately following the event. However, other signs and symptoms may be delayed from days to months (e.g., subdural hematoma, seizures, hydrocephalus, spasticity, etc.). Signs and symptoms may occur alone or in varying combinations and may result in a functional impairment. These signs and symptoms are not better explained by pre-existing conditions or other medical, neurological, or psychological causes except in cases of an exacerbation of a pre-existing condition. These generally fall into one or more of the three following categories:

- Physical: Headache, nausea, vomiting, dizziness, blurred vision, sleep disturbance, weakness, paresis/plegia, sensory loss, spasticity, aphasia, dysphagia, dysarthria, apraxia, balance disorders, disorders of coordination, seizure disorder.

- Cognitive: Attention, concentration, memory, speed of processing, new learning, planning, reasoning, judgment, executive control, self-awareness, language, abstract thinking.

- Behavioral/emotional: Depression, anxiety, agitation, irritability, impulsivity, aggression.

Note: The signs and symptoms listed above are typical of each category but are not an exhaustive list of all possible signs and symptoms.

SEVERITY OF BRAIN INJURY STRATIFICATION:

Not all individuals exposed to an external force will sustain a TBI. TBI varies in severity, traditionally described as mild, moderate and severe. These categories are based on measures of length of unconsciousness, post-traumatic amnesia.

The trauma may cause structural damage or may produce more subtle damage that manifests by altered brain function, without structural damage that can be detected by traditional imaging studies such as Magnetic Resonance Imaging or Computed Tomography scanning. In addition to traditional imaging studies, other imaging techniques such as functional magnetic resonance imaging, diffusion tensor imaging, positron emission tomography scanning, as well as electrophysiological testing such as electroencephalography may be used to detect damage to or physiological alteration of brain function. In addition, altered brain function may be manifest by altered performance on neuropsychological or other standardized testing of function.

Acute injury severity is determined at the time of the injury, but this severity level, while having some prognostic value, does not necessarily reflect the patient's ultimate level of functioning. It is recognized that serial assessments of the patient's cognitive, emotional, behavioral and social functioning is required.

- The patient is classified as mild/moderate/severe if he or she meets any of the criteria below within a particular severity level. If a patient meets criteria in more than one category of severity, the higher severity level is assigned.

- If it is not clinically possible to determine the brain injury level of severity because of medical complications (e.g., medically induced coma), other severity markers are required to make a determination of the severity of the brain injury.

Normal structural imaging	Normal or abnormal structural imaging	Normal or abnormal structural imaging
LOC = 0–30 min*	LOC >30 min and < 24 hours	LOC > 24 hrs
AOC = a moment up to 24 hrs	AOC >24 hours. Severity based on other criteria	
PTA = 0–1 day	PTA >1 and <7 days	PTA > 7 days

AOC – Alteration of consciousness/mental state
LOC – Loss of consciousness
PTA – Post-traumatic amnesia

* An inconsistency currently exists between this published guidance and the published V codes for mild TBI when loss of consciousness is between 30 and 59 minutes. Until this inconsistency is resolved, Services are to report in the attached format using the criteria published above.

It is recognized that the cognitive symptoms associated with post-traumatic stress disorder (PTSD) may overlap with symptoms of mild TBI. Differential diagnosis of brain injury and PTSD is required for accurate diagnosis and treatment.

REPORTING TRAUMATIC BRAIN INJURY

Using the definition and severity criteria in Appendix 1, all Services will submit a monthly report to the Office of Clinical Standards, Defense and Veterans Brain Injury Center (DVBIC). My point of contact is Ms. Athena Kendall-Robbins, *athena.kendall@amedd.army.mil*, (202) 782-3102. Reports must be forwarded by the 15th of the month with the "as of" date being the 1st of the month. Reports should be submitted electronically via encrypted e-mail using the following format:

Patient Name	Patient Age	Gender	Rank	Branch	Patient SSN	Where Wounded	Deployment
Last, First MI	Number	1=Male, 2=Female	(pay scale)	USA, USAR, ARNG, etc.	9 digits no dashes or spaces	1=OIF, 2=OEF, 3=other than OIF/OEF	If deployed, which OIF/OEF deployment is this? 1, 2, 3 etc.
Smith, James D.	23	1	E4	USMC	987654321	1	2

Closed TBI	Penetrating TBI	Injury Agent = Fragment	Injury Agent = Fall	Injury Agent = Bullet	Injury Agent = Blast	Injury Agent = Vehicular	Injury Agent = Other
Yes=1 No=0	Yes=1 No=0	Yes=1 No=0	Yes=1 No=0	Yes=1 No=0	Yes=1 No=0	Yes=1 No=0	Yes=1 No=0
1	0	0	0	0	1	0	0

Date of Injury	Home of Record	Closed TBI Severity	Date of Admission (if applicable)	Date of Discharge (if applicable)	Outcome (if known)	V Code	ICD9 Code
mm/dd/yyyy	Postal Code (e.g. OH for Ohio)	Mild=1 Mod=2 Severe=3 Penetrating=97	mm/dd/yyyy	mm/dd/yyyy	1=Return to Duty 2=Limited Duty 3=Home 4=Home w/Outpnt Support 5=Community Trans Pgrm 6=Nursing Home 7=Med Retirement 8=Pending Med Board		
2/21/2007	NJ	1	2/24/2007	3/25/2007	2	V15.52	850.11

TBI Reporting Database Rules

1. Name:
   - Last name first.
   - First letters of first and last name uppercase, rest are lowercase.
   - Include middle initial if known.
   - Ex: Smith, Robert A.
2. Age:
   - Numerical age.
3. Gender:
   - 1=Male.
   - 2=Female.
4. Rank:
   - No dashes.
   - Ex: E2, O3.
5. Branch:
   - USA=Army Active Duty, ARNG=Army National Guard, USAR=Army Reserve, USMC=Marine Corps Active Duty, USMCR=Marine Corps Reserve, USN=Navy Active Duty, USNR=Navy Reserve, USAF=Air Force Active Duty, ANG=Air National Guard, USAFR=Air Force Reserve, CIV=Civilian
6. SSN:
   - Only include the 9 digit SSN with no dashes.
   - Ex: 987654321.

7. Where Wounded:

- 1=Operation Iraqi Freedom (OIF)
- 2=Operation Enduring Freedom (OEF)
- 3=other than OEF/OIF

8. Deployment:

- Which OIF/OEF deployment was the patient on when injured? (e.g. OIF)

9. Closed TBI:

- 1=Yes
- 0=No

10. Penetrating TBI:

- A penetrating TBI is one in which the duramater of the brain is punctured.
- 1=Yes
- 0=No

Note: Agent of injury is the cause of the TBI. For example, if a patient was shot in the leg, fell and hit his head, his agent of injury would be a fall but not a gunshot wound.

11. Injury Agent=Fragment:

- 1=Yes
- 0=No

12. Injury Agent=Fall:

- 1=Yes
- 0=No

13. Injury Agent=Gunshot wound:
    - 1=Yes
    - 0=No
14. Injury Agent=Blast:
    - 1=Yes
    - 0=No
15. Injury Agent=Vehicular:
    - 1=Yes
    - 0=No
16. Injury Agent=Other:
    - 1=Yes
    - 0=No
17. Date of Injury:
    - mm/dd/yyyy
18. Home of Record:
    - Mailing Address
    - Use postal code for patient's home state.

19. Closed TBI Severity:

- 1=mild
- 2=moderate
- 3=severe
- 97=penetrating

20. Date of Admission (if applicable):

- mm/dd/yyyy

21. Date of Discharge (if applicable):

- mm/dd/yyyy
- Unknown discharge dates will be collected at the end of the calendar year.

22. Discharge Disposition:

- 1=Return to Duty 2=Limited Duty 3=Home 4=Home w/Outpnt Support 5=Community Transitional Program 6=Nursing Home 7=Med Retirement 8=Pending Med Board
- Unknown variables will be collected at the end of the calendar year.

23. V Code

24. International Code of Diseases—9 Codes

nagement Guidance for Mild Traumatic Brain Injury – Acute Non-Deployed Care

[redacted]

cle collision (MVC), head impact)

d, confused or loss of lly)

Are ed Flags[a] present or is CT Scan positive?

Yes → ***Urgent referral to Neurology, Neurosurgery, or Emergency Room as appropriate***

No

Positive findings on uro Exam, ANAM[b], MACE Score <25 or symptoms from Item VIII?

Yes →

Primary Care Management
1. Manage symptoms[c]
2. Provide Education
3. Profile – 7 days
4. Re-evaluate symptoms (Item VIII) and re-administer ANAM[b] within 7 days
5. Consider Neurology referral if clinically indicated

No

Continued symptoms or abnormal ANAM on re-evaluation?

Yes → **1. 30 day profile**
2. Go to Sub-Acute CMG

No

ertional Testing[d]

Positive nptoms with ional exercise testing[d]?

Yes →
1. Provide Education
2. Profile – 7 days
3. Repeat exertional testing[d] in 24 hours

Positive symptoms on exertional testing[d]?

Yes → Repeat exertional testing[d] & re-evaluate symptoms in 7 days

Any new or persistent Symptoms with exertion?

Yes →

No

Reinforce Education
Return to Duty

No

Reinforce Education
Return to Duty

No

ide Education uct to seek f/u if symptoms velop in 1-2 days rn to Duty

[c] **Treatment:**
1. Give educational sheet to all mTBI patients.
2. Headache management - use Acetominophen.
3. Avoid tramadol, narcotics, NSAID's, ASA, or other platelet inhibitors until CT confirmed negative.

[redacted]

ıagement Guideline Mild Traumatic Brain Injury – Sub-Acute

High Risk Group:
1. Injury caused by explosion
2. Injury from fall, MVC, GSW above shoulders

ry Questionnaire – ***Pg. 3***
ıa / current exposure

eadache, Balance, Sleep, Irritability, Memory] – ***Pg. 2***
uster assessments as indicated– ***Pg. 2***

rgent CT Scan
eferral (as indicated by symptom cluster)
rovide Education

mTBI Disposition Decision

	Symptomatic	Disabling Symptoms
Resolving / Responding	**Retain**	**1. Gather collateral information: ANAM, time in service, unit & family feedback** **2. Ensure sufficient trial of OT/PT Rehab** **3. Consider MEB – 12 months**
No Change		**1. Consider MEB – 6 months with collateral information** **2. Initiate MEB – NLT 12 months**
Worsening		

[a] If ANAM is available

[redacted]

Yes
xan
ed[d]?
No

Order CT Scan

Positive CT Scan? — Yes → 1. Neurology Referral (24 hr) 2. Provide Education

No

Symptomatic? — Yes →
1. Manage symptom cluster– ***Pg. 2***
2. Provide Education
3. Profile – up to 3 months
3. Periodic re-evaluation (e.g., every 3 months)
4. Determine final disposition at 12 months or sooner

No

1. Provide Education
2. RTD

[redacted]

blast, fall, MVC, head impact
dazed, confused or loss of
consciousness even momentarily)

[d] **CT Scan Criteria:** CT Scan is indicated in mTBI patients with headache, vomiting, drug or alcohol intoxication, deficits in short term memory, physical evidence of trauma above the clavicle, dizziness, disequilibrium, or age >60.

	Special Assessments by Symptom Cluster	***Assessment Red Flags***	***Treatments by Symptom Cluster*** ***(NOTE: Treat headache, irritability, and sleep first followed by memory. A majority of patients improve on memory with treatment of headache, irritability, and sleep alone).***
	Examine: fundascopic, pupils, visual acuity, extraocular, cerebellar/ coordination (e.g., finger to nose, rapid alternating movements), deep tendon reflexes (DTRs), gait, motor/sensory, trigger points (neck, greater occipital nerve) **REFER:** Any abnormality – 24 hours referral to Neurology ***•ALL dosing and medications listed in this table are suggestions.*** ***•Inclusion in this guidance does NOT imply an FDA approved indication.*** ***•See full prescribing information for details of medication indications, contra-indications, dosing, side-effects, and cautions.***	Worse/ worsening / uncontrolled headache, fever, stiff neck, blackout, seizures **REFER:** Urgent referral to Neurology	**Symptomatic Treatment** (prn at HA onset, up to 3 days/week): Motrin 600-800 mg,; Naprosyn; Fiorinal/Fioricet; Triptans **Avoid:** Narcotics, Tylenol, Excedrin, Fioricet in patients with daily headache due to the risk of rebound headache. **Preventive Treatment*:** *(guided by **comorbid** conditions):* **Insomnia:** tri-cyclic anti-depressants, e.g., Amitryptiline (Elavil) or Nortryptiline (Pamelor) – 10-25 mg QHS starting and increasing every 1-2 weeks prn up to 50-75 mg. ***~OR~*** **Hypertension**: consider Propanolol (Inderal) - 60 mg q day up to 180 mg q day or other beta blocker. ***~OR~*** **Neuropathic Pain:** consider Gabapentin (Neurontin): 300 mg BID up to 900 mg TID. **Regardless of selection of preventive therapy, should have trial of treatment of 4-6 weeks before considered ineffective.* **REFER** to Neurology if patient fails trial of two preventive treatments.
	Examine: ***Dix-Hallpike Maneuver, Romberg,*** nystagmus, positional / postural balance, cerebellar/ coordination (e.g., finger to nose, rapid alternating movements), ENT – otoscopic exam, bedside hearing test, review audiogram if available. **REFER:** Any abnormality – 24 hours referral to Neurology	Lateral abnormality, nystagmus **REFER:** Urgent referral to Neurology	**REFER** to Physical Therapy
g	Administer: ***Epworth Sleepiness Scale*** **History / Symptom questions**: difficulty falling asleep, difficulty staying asleep, acting out in sleep (sleep walking), nightmares, falling out of bed, confusion, frightened arousal, non-restorative sleep, alcohol or other substance abuse. **Examine:** neck size, airway	Apnea **REFER:** Urgent referral to Neurology, Pulmonary Medicine, or other Sleep Lab.	**First Choice** – without other associated symptoms: 7-14 day trial of Trazodone (Desyrel) 25 - 100 mg qHS (response should be seen within 1-14 days); Ambien 5-10mg QHS prn - **LIMIT** therapy to 2 weeks. **Comorbid Conditions**: **Nightmares or other PTSD-related symptoms**: trial of Quetiapine (Seroquel) – dosage starting at 25 mg q hs tapered up to 100 mg over a period of one week (increase every 2 days if no improvement seen up to 100 mg; stabilize at 100 mg for one week before considering ineffective); **Headaches:** trial of Amitriptyline (Elavil) starting at 10 mg q hs and titrated up to doses of 75 – 100 mg if needed, complete trial of 6-8 weeks before considering ineffective. **REFER** to psychiatry if medication trials are ineffective.
	Administer:, ***PCL-M Screening questionnaire*** **Specific history / symptom questions:** physical fighting, alcohol intake, relationship problems, suicidal, homicidal **REFER**: PCL-M Score over 50 – 24 hours referral to Psychiatry, Psychology, Social Work	Outward violence (not just arguing), physical fighting, alcohol intake, relationship problems, suicidal ideation, homicidal ideation, significant decline in function. **REFER:** Urgent referral to Psychiatry, Psychology, Social Work	6 week trial of SSRI / SNRI: **SSRI considerations:** Sertraline (Zoloft) 25 - 150 mg po q day; Citalopram (Celexa) 10-40 mg po q day; or Escitalopram (Lexapro) 10-40 mg po q day. **SNRI considerations:** Venlafaxine (Effexor XR) – start 37.5 mg q day and titrate by 37.5 mg/week up to 150 mg q day. **REFER** to Psychiatry if does not respond after 6 week trial.
,	**Administer:** ***ANAM*** **Gather:** Info from other sources (collateral information) – including family members and supervisor feedback.		**Normalize**: Sleep and Diet/Nutrition **REFER** to Occupational Therapy and Speech/Language Therapy (if available) for cognitive therapy **REFER** to Neuropsychology if there are no other symptoms or after intial treatment of symptom clusters above.

Initial History and Symptoms Questionnaire

have you had
ollowing:

ders)
houlders

2. Did you experience any of the following?
(Mark all that apply)

- O Being dazed, confused, saw stars
- O Knocked out – less than 1 minute
- O Knocked out – 1 - 20 minutes
- O Knocked out – more than 20 minutes
- O Did not remember the injury
- O Bleeding from the ears
- O Head injury
- O Concussion symptoms
- O None of the above

3. Do you have or have you had any of the following symptoms from the injuries?

Right after injury	*Now at rest*	*Now with exertion*	*(Mark all that apply)*
O	O	O	Headaches
O	O	O	Nausea / Vomiting
O	O	O	Sensitivity to bright light or noise
O	O	O	Balance problems / dizziness
O	O	O	Ringing in the ears
O	O	O	Sleep problems
O	O	O	Irritability (short temper)
O	O	O	Memory problems / lapses

ms with regard to how much they have disturbed you IN THE LAST 2 Weeks.
t; not a problem at all
but it does not disrupt my activities; I can usually continue what I'm doing; doesn't really concern me .
ccasionally disrupts my activities; I can usually continue what I'm doing with some effort; I feel somewhat concerned.
and disrupts activities; I can only do things that are fairly simple or take little effort; I feel I need help.
s present and I have been unable to perform at work, school or home due to this problem; I probably cannot function without help.

	0	1	2	3	4
	O	O	O	O	O
	O	O	O	O	O
	O	O	O	O	O
	O	O	O	O	O
	O	O	O	O	O
eing	O	O	O	O	O
	O	O	O	O	O
	O	O	O	O	O
	O	O	O	O	O
/	O	O	O	O	O
	O	O	O	O	O

Symptoms	0	1	2	3	4
Loss of appetite or increased appetite	O	O	O	O	O
Poor concentration, can't pay attention, easily distracted	O	O	O	O	O
Forgetfulness, can't remember things	O	O	O	O	O
Difficulty making decisions	O	O	O	O	O
Slowed thinking, difficulty getting organized, can't finish things	O	O	O	O	O
Fatigue, loss of energy, getting tired easily	O	O	O	O	O
Difficulty falling or staying asleep	O	O	O	O	O
Feeling anxious or tense	O	O	O	O	O
Feeling depressed or sad	O	O	O	O	O
Irritability, easily annoyed	O	O	O	O	O
Poor frustration tolerance, feeling easily overwhelmed by things	O	O	O	O	O

Epworth Sleepiness Scale

off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual
Even if you haven't done some of these things recently try to work out how they would have affected you.

u would doze off in the following situations based on the scale:

1 = *Slight chance of dozing* **2 = *Moderate chance of dozing*** **3 = *High chance of dozing***

	Chance of dozing
ł reading	
TV	
ıctive in a public place (e.g. a theatre or a meeting)	
enger in a car for an hour without a break	
'n to rest in the afternoon when circumstances permit	
ł talking to someone	
etly after a lunch without alcohol	
/hile stopped for a few minutes in the traffic	

Scoring:
0-10 Normal range
10-12 Borderline
12-24 Abnormal

st of problems and complaints that veterans sometimes have in response to stressful military experiences.
fully, fill in the circle to indicate how much you have been bothered by that problem in the last month.

2 = A little bit ***3 = Moderately*** ***4 = Quite a bit*** ***5 = Extremely***

nse:	1	2	3	4	5
ted, disturbing memories, thoughts, or images of a stressful military ence?	O	O	O	O	O
ted, disturbing dreams of a stressful military experience?	O	O	O	O	O
nly acting or feeling as if a stressful military experience were happening again ou were reliving it)?	O	O	O	O	O
g very upset when something reminded you of a stressful military experience?	O	O	O	O	O
g physical reactions (e.g., heart pounding, trouble berating, or sweating) when ning reminded you of a stressful military experience?	O	O	O	O	O
thinking about or talking about a stressful military experience or avoid having gs related to it?	O	O	O	O	O
activities or situations because they remind you of a stressful military ence?	O	O	O	O	O
e remembering important parts of a stressful military experience?	O	O	O	O	O
f interest in things that you used to enjoy?	O	O	O	O	O
g distant or cut off from other people?	O	O	O	O	O
g emotionally numb or being unable to have loving feelings for those close to	O	O	O	O	O
g as if your future will somehow be cut short?	O	O	O	O	O
e falling or staying asleep?	O	O	O	O	O
g irritable or having angry outbursts?	O	O	O	O	O
g difficulty concentrating?	O	O	O	O	O
"super alert" or watchful on guard?	O	O	O	O	O
g jumpy or easily startled?	O	O	O	O	O

Oliver, Jill, CTR, OASD(HA)/TMA

From: Flossos, Anna, CIV, OASD(HA)/TMA
Sent: Tuesday, December 22, 2009 8:39 AM
To: Sipos, Larry, CIV, OASD(HA); Berchelmann, Susan, CTR, OASD(HA)/TMA
Cc: Edwards, Allen, CIV, OASD(HA)/TMA; Mercurius, Sonya, CIV, OASD(HA)/TMA; Oliver, Jill, CTR, OASD(HA)/TMA; Speight, Cynthia, CIV, OASD(HA)/TMA
Subject: RE: Livelinks 172552, 172704 -- Report to Congress
Signed By: anna.flossos@tma.osd.mil

Importance: High

Susan,

Please make sure that the letters are all still in there and the OGC change is NOT made. We have tried to fix this with OGC/OSD(LA) but some how they keep making these edits.

Call me if you have questions.

Thanks!
Anna

Anna S. Flossos
OASD(HA)/TMA
Office: 703.681.5990
Fax: 703.681.0628
-----Original Message-----
From: Sipos, Larry, CIV, OASD(HA)
Sent: Tuesday, December 22, 2009 8:31 AM
To: Flossos, Anna, CIV, OASD(HA)/TMA; Berchelmann, Susan, CTR, OASD(HA)/TMA
Cc: Edwards, Allen, CIV, OASD(HA)/TMA; Mercurius, Sonya, CIV, OASD(HA)/TMA; Oliver, Jill, CTR, OASD(HA)/TMA; Speight, Cynthia, CIV, OASD(HA)/TMA
Subject: RE: Livelinks 172552, 172704 -- Report to Congress

Anna,

Please call Susan. The changes have already been made to the report package and will have to be backed out by the front office.

Susan, please help.

Larry Sipos
Executive Officer to the
Deputy Assistant Secretary of Defense for Force Health Protection and Readiness
703-578-8426
-----Original Message-----
From: Flossos, Anna, CIV, OASD(HA)/TMA
Sent: Tuesday, December 22, 2009 8:23 AM
To: Sipos, Larry, CIV, OASD(HA); Speight, Cynthia, CIV, OASD(HA)/TMA
Cc: Edwards, Allen, CIV, OASD(HA)/TMA; Mercurius, Sonya, CIV, OASD(HA)/TMA; Berchelmann, Susan, CTR, OASD(HA)/TMA; Oliver, Jill, CTR, OASD(HA)/TMA
Subject: RE: Livelinks 172552, 172704 -- Report to Congress

Larry - We keep having this issue with OSD(LA)...please keep the 8 committee letters in the package and keep the language the same.

Thanks!!

Anna

Anna S. Flossos
OASD(HA)/TMA
Office: 703.681.5990
Fax: 703.681.0628
-----Original Message-----
From: Sipos, Larry, CIV, OASD(HA)
Sent: Tuesday, December 22, 2009 8:21 AM
To: Speight, Cynthia, CIV, OASD(HA)/TMA
Cc: Edwards, Allen, CIV, OASD(HA)/TMA; Flossos, Anna, CIV, OASD(HA)/TMA; Mercurius, Sonya, CIV, OASD(HA)/TMA; Berchelmann, Susan, CTR, OASD(HA)/TMA; Oliver, Jill, CTR, OASD(HA)/TMA
Subject: Livelinks 172552, 172704 -- Report to Congress

Cyndi,

The referenced interim report to Congress was changed per OLA to delete the letters to the Appropriations committees. Apparently, there must be new guidance on RTCs. We've been under the impression that we always send such reports to 8 committees. That's what we did for the previous interim.

In addition, it was my understanding that for reporting requirements that are in the Bill/Act, that we say that congress "requires," but that if the reporting requirement is in the Committee report, that we say congress "requests." Again, something has changed. Where we said "requires" in the previous RTC, either OLA or OGC changed it to "requests" for this RTC.

Please advise on what are the current guidelines.

Larry
703-578-8426

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JAN 22 2010

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Section 1664 of the National Defense Authorization Act for Fiscal Year 2008 requires that the Secretary of Defense and the Secretary of Veterans Affairs to jointly submit a report describing the changes undertaken within their Departments to ensure that Service members and veterans with traumatic brain injury (TBI) receive a medical designation concomitant with their injury. In July 2008 and again in January 2009, we submitted reports of the progress of actions underway with the intent to provide a final report after the proposed coding changes were accepted and released by the National Center for Health Statistics (NCHS).

Previous coding classifications prevented adequate characterization of the spectrum of TBI and its symptomatic manifestations, a problem known to the medical community at large. Responding to this problem, the Department of Defense (DoD) and the Department of Veterans Affairs (VA) clinical and medical coding communities developed a consolidated coding revision proposal to change the current TBI coding classifications.

On August 1, 2009, the NCHS announced the new emotional and behavioral symptom codes. The changes became effective on October 1, 2009, and will allow TBI-related emotional and behavioral symptoms to be coded and classified without using mental health diagnosis codes. In addition, two new TBI-specific codes were announced. Additional changes involved cognitive and memory symptoms, but NCHS delayed their implementation to allow additional time for interested parties to disentangle the many codes that describe cognitive and memory symptoms.

The public comment period closed in November, and comments are being evaluated. If there are no substantive changes resulting from the comments, the cognitive symptoms codes will be announced in August 2010 and become effective in October 2010. If significant changes are required, we will present a revised cognitive symptom coding proposal at the March 2010 Coordination and Maintenance Committee meeting.

This will be followed by another period of public comment before an August 2010 announcement of the results. Meanwhile, we continue our efforts to ensure the acceptance of the new cognitive and memory symptom codes.

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Thank you for your continued support of the Military and Veterans Health Systems.

Sincerely,

Ellen P. Embrey

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Deputy Assistant Secretary of Defense
(Force Health Protection and Readiness)
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cc:
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cc:
The Honorable Thad Cochran
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

The Honorable Daniel K. Inouye
Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

JAN 22 2010

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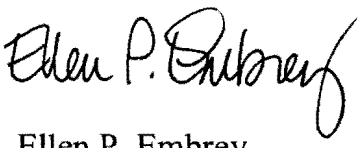

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cc:
The Honorable Thad Cochran
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

JAN 22 2010

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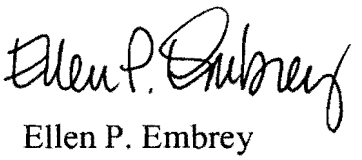

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cc:
The Honorable Jerry Lewis
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

The Honorable John P. Murtha
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

JAN 22 2010

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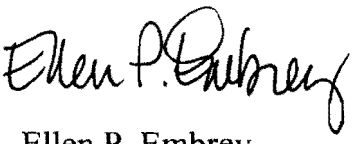

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cc:
The Honorable C. W. Bill Young
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JAN 22 2010

The Honorable James H. Webb
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

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HEALTH AFFAIRS

JAN 22 2010

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Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Ranking Member

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WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JAN 22 2010

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Committee on Armed Services
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HEALTH AFFAIRS

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Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

FEB 04 2010

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Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

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HEALTH AFFAIRS

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United States Senate
Washington, DC 20510

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HEALTH AFFAIRS

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On August 1, 2009, the NCHS announced the new emotional and behavioral symptom codes. The changes became effective on October 1, 2009, and will allow TBI-related emotional and behavioral symptoms to be coded and classified without using mental health diagnosis codes. In addition, two new TBI-specific codes were announced. Additional changes involved cognitive and memory symptoms, but NCHS delayed their implementation to allow additional time for interested parties to disentangle the many codes that describe cognitive and memory symptoms.

The public comment period closed in November, and comments are being evaluated. If there are no substantive changes resulting from the comments, the cognitive symptoms codes will be announced in August 2010 and become effective in October 2010. If significant changes are required, we will present a revised cognitive symptom coding proposal at the March 2010 Coordination and Maintenance Committee meeting.

This will be followed by another period of public comment before an August 2010 announcement of the results. Meanwhile, we continue our efforts to ensure the acceptance of the new cognitive and memory symptom codes.

DoD and VA have made great progress in effecting change for TBI coding classification within the medical community at large. These changes are pivotal in ensuring that Service members with TBI receive a medical designation concomitant with their injury, rather than a medical designation that assigns a generic classification. We will provide a final report to Congress on the implementation of new TBI codes in October 2010, after the new cognitive and memory codes for TBI have been published.

Thank you for your continued support of the Military and Veterans Health Systems.

Sincerely,

Allen W. Middleton
Director, Financial Plans and Policy
Performing the Duties of the
Assistant Secretary of Defense
(Health Affairs)

cc:
The Honorable Joe Wilson
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

FEB 04 2010

The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

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Ranking Member

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HEALTH AFFAIRS

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

FEB 04 2010

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(Health Affairs)

cc:
The Honorable Jerry Lewis
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

FEB 04 2010

The Honorable John P. Murtha
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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