



Approved Diagnostic Codes for Persons with Related Conditions Effective October 1, 2026 to September 30, 2027

The following diagnostic codes are found in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), 2027, and are recognized by the Health and Human Services Commission (HHSC) as conditions which might qualify an individual as having a related condition as described in federal and state law.

In accordance with the Code of Federal Regulations, Title 42, 435.1010, a related condition is a severe and chronic disability that:

- A. is attributed to:
 - i cerebral palsy or epilepsy; or
 - ii any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with intellectual disability, and requires treatment or services similar to those required for individuals with intellectual disability;
- B. is manifested before the individual reaches age 22;
- C. is likely to continue indefinitely; and
- D. results in substantial functional limitation in at least three of the following areas of major life activity:
 - i self-care;
 - ii understanding and use of language;
 - iii learning;
 - iv mobility;
 - v self-direction; and
 - vi capacity for independent living.

A primary diagnosis by a licensed physician (or designee as defined in program rules) of a related condition may be required to meet eligibility for the following Medicaid programs:

- Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID);
- Community Living Assistance and Support Services (CLASS);
- Home and Community-based Services (HCS);
- Texas Home Living (TxHmL); and
- Deaf Blind with Multiple Disabilities (DBMD).

Please refer to the applicable rules governing those programs for complete information regarding eligibility.

Disclaimer: the ICD-10 codes contained in the following list are subject to change at least once a year on October 1, but can also change during the year.

Approved Diagnostic Codes for Persons with Related Conditions Effective October 1, 2026 to September 30, 2027

No codes were removed or added from the previous HHSC-Approved Diagnostic Codes for Persons with Related Conditions List.

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
B91	Sequelae of poliomyelitis
C71.1	Malignant neoplasm of frontal lobe
C71.2	Malignant neoplasm of temporal lobe
C71.3	Malignant neoplasm of parietal lobe
C71.4	Malignant neoplasm of occipital lobe
C71.5	Malignant neoplasm of cerebral ventricle
C71.6	Malignant neoplasm of cerebellum
C71.7	Malignant neoplasm of brain stem
C71.8	Malignant neoplasm of overlapping sites of brain
C71.9	Malignant neoplasm of brain, unspecified
C79.31	Secondary malignant neoplasm of brain

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
C96.0	Multifocal and multisystemic (disseminated) Langerhans-cell histiocytosis
C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis
C96.6	Unifocal Langerhans-cell histiocytosis
D42.0	Neoplasm of uncertain behavior of cerebral meninges
D42.1	Neoplasm of uncertain behavior of spinal meninges
D42.9	Neoplasm of uncertain behavior of meninges, unspecified
D43.0	Neoplasm of uncertain behavior of brain, supratentorial
D43.1	Neoplasm of uncertain behavior of brain, infratentorial
D43.2	Neoplasm of uncertain behavior of brain, unspecified
D43.4	Neoplasm of uncertain behavior of spinal cord
D44.0	Neoplasm of uncertain behavior of thyroid gland
D44.10	Neoplasm of uncertain behavior of unspecified adrenal gland
D44.11	Neoplasm of uncertain behavior of right adrenal gland
D44.12	Neoplasm of uncertain behavior of left adrenal gland
D44.2	Neoplasm of uncertain behavior of parathyroid gland
D44.3	Neoplasm of uncertain behavior of pituitary gland
D44.4	Neoplasm of uncertain behavior of craniopharyngeal duct
D44.5	Neoplasm of uncertain behavior of pineal gland
D44.6	Neoplasm of uncertain behavior of carotid body
D44.7	Neoplasm of uncertain behavior of aortic body and other paraganglia
D44.9	Neoplasm of uncertain behavior of unspecified endocrine gland
D49.6	Neoplasm of unspecified behavior of brain
D69.42	Congenital and hereditary thrombocytopenia purpura
D69.49	Other primary thrombocytopenia
D82.1	Di Georges syndrome
E00.0	Congenital iodine-deficiency syndrome, neurological type
E00.1	Congenital iodine-deficiency syndrome, myxedematous type
E00.2	Congenital iodine-deficiency syndrome, mixed type
E00.9	Congenital iodine-deficiency syndrome, unspecified

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
E03.0	Congenital hypothyroidism with diffuse goiter
E03.1	Congenital hypothyroidism without goiter
E03.2	Hypothyroidism due to medicaments and other exogenous substances
E03.3	Postinfectious hypothyroidism
E03.9	Hypothyroidism, unspecified
E20.1	Pseudohypoparathyroidism
E21.0	Primary hyperparathyroidism
E21.1	Secondary hyperparathyroidism, not elsewhere classified
E21.2	Other hyperparathyroidism
E21.3	Hyperparathyroidism, unspecified
E72.03	Lowes syndrome
E72.81	Disorders of gamma aminobutyric acid metabolism
E72.89	Other specified disorders of amino-acid metabolism
E75.00	GM2 gangliosidosis, unspecified
E75.02	Tay-Sachs disease
E75.09	Other GM2 gangliosidosis
E75.19	Other gangliosidosis
E75.21	Fabry (-Anderson) disease
E75.22	Gaucher disease
E75.23	Krabbe disease
E75.240	Niemann-Pick disease type A
E75.241	Niemann-Pick disease type B
E75.242	Niemann-Pick disease type C
E75.243	Niemann-Pick disease type D
E75.244	Niemann-Pick disease type A/B
E75.248	Other Niemann-Pick disease
E75.249	Niemann-Pick disease, unspecified
E75.25	Metachromatic leukodystrophy
E75.29	Other sphingolipidosis

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
E75.4	Neuronal ceroid lipofuscinosis
E76.01	Hurlers syndrome
E76.02	Hurler-Scheie syndrome
E76.03	Scheies syndrome
E76.1	Mucopolysaccharidosis, type II
E76.210	Morquio A mucopolysaccharidoses
E76.211	Morquio B mucopolysaccharidoses
E76.219	Morquio mucopolysaccharidoses, unspecified
E76.22	Sanfilippo mucopolysaccharidoses
E79.1	Lesch-Nyhan syndrome
E79.2	Myoadenylate deaminase deficiency
E79.81	Aicardi-Goutieres Syndrome
E79.82	Hereditary Xanthinuria
E79.89	Other disorders of purine and pyrimidine metabolism
E83.59	Other disorders of calcium metabolism
E88.9	Metabolic disorder, unspecified
E89.0	Postprocedural hypothyroidism
F07.0	Personality change due to known physiological condition
F07.81	Postconcussional syndrome
F09	Unspecified mental disorder due to known physiological condition
F84.0	Autistic disorder
F84.2	Retts syndrome
F84.3	Other childhood disintegrative disorder
F84.5	Aspergers Syndrome
F84.8	Other pervasive developmental disorders
F84.9	Pervasive developmental disorder, unspecified
F95.2	Tourettes disorder
G00.9	Bacterial meningitis, unspecified
G04.90	Encephalitis and encephalomyelitis, unspecified

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
G04.91	Myelitis, unspecified
G05.3	Encephalitis and encephalomyelitis in diseases classified elsewhere
G05.4	Myelitis in diseases classified elsewhere
G10	Huntingtons disease
G11.10	Early-onset cerebellar ataxia, unspecified
G11.11	Friedreich ataxia
G11.19	Other early-onset cerebellar ataxia
G11.3	Cerebellar ataxia with defective DNA repair
G11.4	Hereditary Spastic Paraparesis/Paraplegia
G12.1	Other inherited spinal muscular atrophy
G12.9	Spinal muscular atrophy, unspecified
G14	Postpolio syndrome
G20.A1	Parkinson's dis w/o dyskinesia, w/o mention of fluctuations
G20.A2	Parkinson's disease without dyskinesia, with fluctuations
G20.B1	Parkinson's dis with dyskinesia, w/o mention of fluctuations
G20.B2	Parkinson's disease with dyskinesia, with fluctuations
G20.C	Parkinsonism, unspecified
G21.11	Neuroleptic induced parkinsonism
G21.19	Other drug induced secondary parkinsonism
G21.2	Secondary parkinsonism due to other external agents
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
G24.1	Genetic torsion dystonia
G31.01	Picks disease

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
G31.81	Alpers disease
G31.82	Leighs disease
G31.89	Other specified degenerative diseases of nervous system
G35.A	Relapsing-remitting multiple sclerosis
G35.B	Primary progressive multiple sclerosis
G35.B0	Primary progressive multiple sclerosis, unspecified
G35.B1	Active primary progressive multiple sclerosis
G35.B2	Non-active primary progressive multiple sclerosis
G35.C	Secondary progressive multiple sclerosis
G35.C0	Secondary progressive multiple sclerosis, unspecified
G35.C1	Active secondary progressive multiple sclerosis
G35.C2	Non-active secondary progressive multiple sclerosis
G35.D	Multiple sclerosis, unspecified
G37.9	Demyelinating disease of central nervous system, unspecified
G40.101	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, with status epilepticus
G40.109	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus
G40.111	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus
G40.119	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus
G40.201	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, with status epilepticus
G40.209	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus
G40.211	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, with status epilepticus

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
G40.219	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus
G40.301	Generalized idiopathic epilepsy and epileptic syndromes, not intractable, with status epilepticus
G40.309	Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40.311	Generalized idiopathic epilepsy and epileptic syndromes, intractable, with status epilepticus
G40.319	Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus
G40.401	Other generalized epilepsy and epileptic syndromes, not intractable, with status epilepticus
G40.409	Other generalized epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40.411	Other generalized epilepsy and epileptic syndromes, intractable, with status epilepticus
G40.419	Other generalized epilepsy and epileptic syndromes, intractable, without status epilepticus
G40.801	Other epilepsy, not intractable, with status epilepticus
G40.802	Other epilepsy, not intractable, without status epilepticus
G40.803	Other epilepsy, intractable, with status epilepticus
G40.804	Other epilepsy, intractable, without status epilepticus
G40.821	Epileptic spasms, not intractable, with status epilepticus
G40.822	Epileptic spasms, not intractable, without status epilepticus
G40.823	Epileptic spasms, intractable, with status epilepticus
G40.824	Epileptic spasms, intractable, without status epilepticus
G40.89	Other Seizures
G40.901	Epilepsy, unspecified, not intractable, with status epilepticus
G40.909	Epilepsy, unspecified, not intractable, without status epilepticus
G40.911	Epilepsy, unspecified, intractable, with status epilepticus
G40.919	Epilepsy, unspecified, intractable, without status epilepticus
G40.A01	Absence epileptic syndrome, not intractable, with status epilepticus

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
G40.A09	Absence epileptic syndrome, not intractable, without status epilepticus
G40.A11	Absence epileptic syndrome, intractable, with status epilepticus
G40.A19	Absence epileptic syndrome, intractable, without status epilepticus
G40.B01	Juvenile myoclonic epilepsy, not intractable, with status epilepticus
G40.B09	Juvenile myoclonic epilepsy, not intractable, without status epilepticus
G40.B11	Juvenile myoclonic epilepsy, intractable, with status epilepticus
G40.B19	Juvenile myoclonic epilepsy, intractable, without status epilepticus
G50.0	Trigeminal neuralgia
G70.00	Myasthenia gravis without (acute) exacerbation
G71.01	Duchenne or Becker muscular dystrophy
G71.02	Facioscapulohumeral muscular dystrophy
G71.09	Other specified muscular dystrophies
G71.11	Myotonic muscular dystrophy
G71.20	Congenital myopathy, unspecified
G71.21	Nemaline myopathy
G71.220	X-linked myotubular myopathy
G71.228	Other centronuclear myopathy
G71.29	Other congenital myopathy
G80.0	Spastic quadriplegic cerebral palsy
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G80.3	Athetoid cerebral palsy
G80.8	Other cerebral palsy
G80.9	Cerebral palsy, unspecified
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

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
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
G82.20	Paraplegia, unspecified
G82.21	Paraplegia, complete
G82.22	Paraplegia, incomplete
G82.50	Quadriplegia, unspecified
G82.51	Quadriplegia, C1-C4 complete
G82.52	Quadriplegia, C1-C4 incomplete
G82.53	Quadriplegia, C5-C7 complete
G82.54	Quadriplegia, C5-C7 incomplete
G83.0	Diplegia of upper limbs
G83.10	Monoplegia of lower limb affecting unspecified side
G83.11	Monoplegia of lower limb affecting right dominant side
G83.12	Monoplegia of lower limb affecting left dominant side
G83.13	Monoplegia of lower limb affecting right nondominant side
G83.14	Monoplegia of lower limb affecting left nondominant side
G83.20	Monoplegia of upper limb affecting unspecified side
G83.21	Monoplegia of upper limb affecting right dominant side
G83.22	Monoplegia of upper limb affecting left dominant side
G83.23	Monoplegia of upper limb affecting right nondominant side
G83.24	Monoplegia of upper limb affecting left nondominant side
G83.31	Monoplegia, unspecified affecting right dominant side
G83.32	Monoplegia, unspecified affecting left dominant side
G83.33	Monoplegia, unspecified affecting right nondominant side
G83.34	Monoplegia, unspecified affecting left nondominant side

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
G83.4	Cauda equina syndrome
G83.5	Locked-in state
G83.89	Other specified paralytic syndromes
G83.9	Paralytic syndrome, unspecified
G90.1	Familial dysautonomia [Riley-Day]
G91.0	Communicating hydrocephalus
G91.1	Obstructive hydrocephalus
G93.0	Cerebral cysts
G93.1	Anoxic brain damage, not elsewhere classified
G93.40	Encephalopathy, unspecified
G93.7	Reyes syndrome
G93.9	Disorder of brain, unspecified
G94	Other disorders of brain in diseases classified elsewhere
G95.9	Disease of spinal cord, unspecified
G96.9	Disorder of central nervous system, unspecified
H47.10	unspecified papilledema
H47.619	cortical blindness, unspecified site of brain
H47.639	Disorders of visual cortex in (due to) neoplasm, unspecified side of brain
H54.10	Blindness, one eye, low vision other eye, unspecified eyes
H54.1131	Blindness right eye category 3, low vision left eye category 1
H54.1132	Blindness right eye category 3, low vision left eye category 2
H54.1141	Blindness right eye category 4, low vision left eye category 1
H54.1142	Blindness right eye category 4, low vision left eye category 2
H54.1151	Blindness right eye category 5, low vision left eye category 1
H54.1152	Blindness right eye category 5, low vision left eye category 2
H54.1213	Low vision right eye category 1, blindness left eye category 3
H54.1214	Low vision right eye category 1, blindness left eye category 4
H54.1215	Low vision right eye category 1, blindness left eye category 5
H54.1223	Low vision right eye category 2, blindness left eye category 3

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
H54.1224	Low vision right eye category 2, blindness left eye category 4
H54.1225	Low vision right eye category 2, blindness left eye category 5
H54.2X11	Low vision right eye category 1, low vision left eye category 1
H54.2X12	Low vision right eye category 1, low vision left eye category 2
H54.2X21	Low vision right eye category 2, low vision left eye category 1
H54.2X22	Low vision right eye category 2, low vision left eye category 2
H54.3	Unqualified visual loss, both eyes
H54.40	Blindness, one eye, unspecified eye
H54.413A	Blindness right eye category 3, normal vision left eye
H54.414A	Blindness right eye category 4, normal vision left eye
H54.415A	Blindness right eye category 5, normal vision left eye
H54.42A3	Blindness left eye category 3, normal vision right eye
H54.42A4	Blindness left eye category 4, normal vision right eye
H54.42A5	Blindness left eye category 5, normal vision right eye
H54.50	Low vision, one eye, unspecified eye
H54.511A	Low vision right eye category 1, normal vision left eye
H54.512A	Low vision right eye category 2, normal vision left eye
H54.52A1	Low vision left eye category 1, normal vision right eye
H54.52A2	Low vision left eye category 2, normal vision right eye
H54.60	Unqualified visual loss, one eye, unspecified
H54.61	Unqualified visual loss, right eye, normal vision left eye
H54.62	Unqualified visual loss, left eye, normal vision right eye
H54.7	Unspecified visual loss
H54.8	Legal blindness, as defined in USA
H90.0	Conductive hearing loss, bilateral
H90.11	Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
H90.12	Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
H90.2	Conductive hearing loss, unspecified

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
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
H91.3	Deaf nonspeaking, not elsewhere classified
H91.8X1	Other specified hearing loss, right ear
H91.8X2	Other specified hearing loss, left ear
H91.8X9	Other specified hearing loss, unspecified ear
H91.90	Unspecified hearing loss, unspecified ear
H91.91	Unspecified hearing loss, right ear
H91.92	Unspecified hearing loss, left ear
H91.93	Unspecified hearing loss, bilateral
I67.9	Cerebrovascular disease, unspecified
I69.041	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right dominant side
I69.042	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting left dominant side
I69.043	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right non- dominant side
I69.044	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting left non- dominant side
I69.049	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting unspecified side
I69.051	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
I69.052	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side
I69.053	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right non- dominant side
I69.054	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non- dominant side
I69.059	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting unspecified side
I69.141	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting right dominant side
I69.143	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting right non- dominant side
I69.144	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting left non-dominant side
I69.149	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting unspecified side
I69.151	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side
I69.152	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side
I69.153	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right non- dominant side
I69.154	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side
I69.159	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting unspecified side
I69.241	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting right dominant side
I69.242	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting left dominant side
I69.243	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting right non-dominant side
I69.244	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting left non-dominant side
I69.249	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting unspecified side

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
I69.251	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side
I69.252	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left dominant side
I69.253	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right non-dominant side
I69.254	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left non-dominant side
I69.259	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting unspecified side
I69.341	Monoplegia of lower limb following cerebral infarction affecting right dominant side
I69.342	Monoplegia of lower limb following cerebral infarction affecting left dominant side
I69.343	Monoplegia of lower limb following cerebral infarction affecting right non-dominant side
I69.344	Monoplegia of lower limb following cerebral infarction affecting left non-dominant side
I69.349	Monoplegia of lower limb following cerebral infarction affecting unspecified side
I69.351	Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
I69.352	Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side
I69.353	Hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side
I69.354	Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side
I69.359	Hemiplegia and hemiparesis following cerebral infarction affecting unspecified side
I69.841	Monoplegia of lower limb following other cerebrovascular disease affecting right dominant side
I69.842	Monoplegia of lower limb following other cerebrovascular disease affecting left dominant side
I69.843	Monoplegia of lower limb following other cerebrovascular disease affecting right non-dominant side

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
I69.844	Monoplegia of lower limb following other cerebrovascular disease affecting left non-dominant side
I69.849	Monoplegia of lower limb following other cerebrovascular disease affecting unspecified side
I69.851	Hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side
I69.852	Hemiplegia and hemiparesis following other cerebrovascular disease affecting left dominant side
I69.853	Hemiplegia and hemiparesis following other cerebrovascular disease affecting right non-dominant side
I69.854	Hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side
I69.859	Hemiplegia and hemiparesis following other cerebrovascular disease affecting unspecified side
I69.941	Monoplegia of lower limb following unspecified cerebrovascular disease affecting right dominant side
I69.942	Monoplegia of lower limb following unspecified cerebrovascular disease affecting left dominant side
I69.943	Monoplegia of lower limb following unspecified cerebrovascular disease affecting right non-dominant side
I69.944	Monoplegia of lower limb following unspecified cerebrovascular disease affecting left non-dominant side
I69.949	Monoplegia of lower limb following unspecified cerebrovascular disease affecting unspecified side
I69.951	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side
I69.952	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side
I69.953	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right non-dominant side
I69.954	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side
I69.959	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side
M08.00	Unspecified juvenile rheumatoid arthritis of unspecified site
M08.09	Unspecified juvenile rheumatoid arthritis, multiple sites

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
M33.20	Polymyositis, organ involvement unspecified
M33.29	Polymyositis with other organ involvement
M62.3	Immobility syndrome (paraplegic)
P04.3	Newborn (suspected to be) affected by maternal use of alcohol
P11.5	Birth injury to spine and spinal cord
P35.0	Congenital rubella syndrome
P84	Other problems with newborn
P90	Convulsions of newborn
P91.811	Neonatal encephalopathy in diseases classified elsewhere
P91.819	Neonatal encephalopathy, unspecified
P91.88	Other specified disturbances of cerebral status of newborn
Q01.0	Frontal encephalocele
Q01.1	Nasofrontal encephalocele
Q01.2	Occipital encephalocele
Q01.8	Encephalocele of other sites
Q01.9	Encephalocele, unspecified
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
Q04.9	Congenital malformation of brain, unspecified
Q05.0	Cervical spina bifida with hydrocephalus
Q05.1	Thoracic spina bifida with hydrocephalus
Q05.2	Lumbar spina bifida with hydrocephalus
Q05.4	Unspecified spina bifida with hydrocephalus

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
Q05.5	Cervical spina bifida without hydrocephalus
Q05.6	Thoracic spina bifida without hydrocephalus
Q05.7	Lumbar spina bifida without hydrocephalus
Q05.9	Spina bifida, unspecified
Q06.9	Congenital malformation of spinal cord, unspecified
Q07.8	Other specified congenital malformations of nervous system
Q07.9	Congenital malformation of nervous system, unspecified
Q11.1	Other anophthalmos
Q15.8	Other specified congenital malformations of eye
Q18.8	Other specified congenital malformations of face and neck
Q27.8	Other specified congenital malformations of peripheral vascular system
Q28.8	Other specified congenital malformations of circulatory system
Q34.8	Other specified congenital malformations of respiratory system
Q40.2	Other specified congenital malformations of stomach
Q40.8	Other specified congenital malformations of upper alimentary tract
Q43.8	Other specified congenital malformations of intestine
Q52.8	Other specified congenital malformations of female genitalia
Q55.8	Other specified congenital malformations of male genital organs
Q62.2	Congenital megaureter
Q63.8	Other specified congenital malformations of kidney
Q68.8	Other specified congenital musculoskeletal deformities
Q69.9	Polydactyly, unspecified
Q71.10	Congenital absence of unspecified upper arm and forearm with hand present
Q71.11	Congenital absence of right upper arm and forearm with hand present
Q71.12	Congenital absence of left upper arm and forearm with hand present
Q71.13	Congenital absence of upper arm and forearm with hand present, bilateral
Q71.20	Congenital absence of both forearm and hand, unspecified upper limb

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
Q71.21	Congenital absence of both forearm and hand, right upper limb
Q71.22	Congenital absence of both forearm and hand, left upper limb
Q71.23	Congenital absence of both forearm and hand, bilateral
Q74.3	Arthrogryposis multiplex congenita
Q74.8	Other specified congenital malformations of limb(s)
Q75.001	Craniosynostosis unspecified, unilateral
Q75.002	Craniosynostosis unspecified, bilateral
Q75.009	Craniosynostosis unspecified
Q75.01	Sagittal craniosynostosis
Q75.021	Coronal craniosynostosis unilateral
Q75.022	Coronal craniosynostosis bilateral
Q75.029	Coronal craniosynostosis unspecified
Q75.03	Metopic craniosynostosis
Q75.041	Lambdoid craniosynostosis, unilateral
Q75.042	Lambdoid craniosynostosis, bilateral
Q75.049	Lambdoid craniosynostosis, unspecified
Q75.051	Cloverleaf skull
Q75.052	Pansynostosis
Q75.058	Other multi-suture craniosynostosis
Q75.08	Other single-suture craniosynostosis
Q75.1	Craniofacial dysostosis
Q75.2	Hypertelorism
Q75.8	Other specified congenital malformations of skull and face bones
Q77.0	Achondrogenesis
Q77.1	Thanatophoric short stature
Q77.3	Chondrodysplasia punctata
Q77.5	Diastrophic dysplasia
Q78.0	Osteogenesis imperfecta
Q78.5	Metaphyseal dysplasia

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
Q78.8	Other specified osteochondrodysplasias
Q78.9	Osteochondrodysplasia, unspecified
Q85.00	Neurofibromatosis, unspecified
Q85.01	Neurofibromatosis, type 1
Q85.02	Neurofibromatosis, type 2
Q85.03	Schwannomatosis
Q85.09	Other neurofibromatosis
Q85.1	Tuberous sclerosis
Q86.0	Fetal alcohol syndrome (dysmorphic)
Q86.8	Other congenital malformation syndromes due to known exogenous causes
Q87.0	Congenital malformation syndromes predominantly affecting facial appearance
Q87.11	Prader-Willi syndrome
Q87.19	Other congenital malformation syndromes predominantly associated with short stature
Q87.2	Congenital malformation syndromes predominantly involving limbs
Q87.3	Congenital malformation syndromes involving early overgrowth
Q87.40	Marfans syndrome, unspecified
Q87.410	Marfans syndrome with aortic dilation
Q87.418	Marfans syndrome with other cardiovascular manifestations
Q87.42	Marfans syndrome with ocular manifestations
Q87.43	Marfans syndrome with skeletal manifestation
Q87.5	Other congenital malformation syndromes with other skeletal changes
Q87.81	Alport syndrome
Q87.89	Other specified congenital malformation syndromes, not elsewhere classified
Q89.3	Situs inversus
Q89.7	Multiple congenital malformations, not elsewhere classified
Q89.81	Kabuki syndrome
Q89.89	Other specified congenital malformations

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
Q90.0	Trisomy 21, nonmosaicism (meiotic nondisjunction)
Q90.1	Trisomy 21, mosaicism (mitotic nondisjunction)
Q90.2	Trisomy 21, translocation
Q90.9	Down syndrome, unspecified
Q91.0	Trisomy 18, nonmosaicism (meiotic nondisjunction)
Q91.1	Trisomy 18, mosaicism (mitotic nondisjunction)
Q91.2	Trisomy 18, translocation
Q91.3	Trisomy 18, unspecified
Q91.4	Trisomy 13, nonmosaicism (meiotic nondisjunction)
Q91.5	Trisomy 13, mosaicism (mitotic nondisjunction)
Q91.6	Trisomy 13, translocation
Q91.7	Trisomy 13, unspecified
Q92.8	Other specified trisomies and partial trisomies of autosomes
Q93.3	Deletion of short arm of chromosome 4
Q93.4	Deletion of short arm of chromosome 5
Q93.51	Angelman syndrome
Q93.7	Deletions with other complex rearrangements
Q93.81	Velo-cardio-facial syndrome
Q93.82	Williams Syndrome
Q93.88	Other microdeletions
Q93.89	Other deletions from the autosomes
Q93.9	Deletion from autosomes, unspecified
Q96.0	Karyotype 45, X
Q96.4	Mosaicism, 45, X/other cell line(s) with abnormal sex chromosome
Q96.8	Other variants of Turners syndrome
Q96.9	Turners syndrome, unspecified
Q98.0	Klinefelter syndrome karyotype 47, XXY
Q98.1	Klinefelter syndrome, male with more than two X chromosomes
Q98.4	Klinefelter syndrome, unspecified

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
Q99.2	Fragile X chromosome
Q99.81	Usher syndrome
Q99.811	Usher syndrome, type 1
Q99.812	Usher syndrome, type 2
Q99.813	Usher syndrome, type 3
Q99.818	Other Usher syndrome
Q99.819	Usher syndrome, unspecified
Q99.89	Other specified chromosome abnormalities
Q99.9	Chromosomal abnormality, unspecified
S01.101A	Unspecified open wound of right eyelid and periocular area, initial encounter
S01.101D	Unspecified open wound of right eyelid and periocular area, subsequent encounter
S01.101S	Unspecified open wound of right eyelid and periocular area, sequela
S01.102A	Unspecified open wound of left eyelid and periocular area, initial encounter
S01.102S	Unspecified open wound of left eyelid and periocular area, sequela
S01.109A	Unspecified open wound of unspecified eyelid and periocular area, initial encounter
S01.109D	Unspecified open wound of unspecified eyelid and periocular area, subsequent encounter
S01.109S	Unspecified open wound of unspecified eyelid and periocular area, sequela
S01.111A	Laceration without foreign body of right eyelid and periocular area, initial encounter
S01.112A	Laceration without foreign body of left eyelid and periocular area, initial encounter
S01.119A	Laceration without foreign body of unspecified eyelid and periocular area, initial encounter
S01.121A	Laceration with foreign body of right eyelid and periocular area, initial encounter
S01.121D	Laceration with foreign body of right eyelid and periocular area, subsequent encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S01.121S	Laceration with foreign body of right eyelid and periocular area, sequela
S01.122A	Laceration with foreign body of left eyelid and periocular area, initial encounter
S01.122D	Laceration with foreign body of left eyelid and periocular area, subsequent encounter
S01.122S	Laceration with foreign body of left eyelid and periocular area, sequela
S01.129A	Laceration with foreign body of unspecified eyelid and periocular area, initial encounter
S01.129D	Laceration with foreign body of unspecified eyelid and periocular area, subsequent encounter
S01.129S	Laceration with foreign body of unspecified eyelid and periocular area, sequela
S01.131A	Puncture wound without foreign body of right eyelid and periocular area, initial encounter
S01.132A	Puncture wound without foreign body of left eyelid and periocular area, initial encounter
S01.139A	Puncture wound without foreign body of unspecified eyelid and periocular area, initial encounter
S01.141A	Puncture wound with foreign body of right eyelid and periocular area, initial encounter
S01.142A	Puncture wound with foreign body of left eyelid and periocular area, initial encounter
S01.149A	Puncture wound with foreign body of unspecified eyelid and periocular area, initial encounter
S01.151A	Open bite of right eyelid and periocular area, initial encounter
S01.151D	Open bite of right eyelid and periocular area, subsequent encounter
S01.151S	Open bite of right eyelid and periocular area, sequela
S01.152A	Open bite of left eyelid and periocular area, initial encounter
S01.152D	Open bite of left eyelid and periocular area, subsequent encounter
S01.152S	Open bite of left eyelid and periocular area, sequela
S01.159A	Open bite of unspecified eyelid and periocular area, initial encounter
S01.159D	Open bite of unspecified eyelid and periocular area, subsequent encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S01.159S	Open bite of unspecified eyelid and periocular area, sequela
S01.90xA	Unspecified open wound of unspecified part of head, initial encounter
S02.0xxA	Fracture of vault of skull, initial encounter for closed fracture
S02.0xxB	Fracture of vault of skull, initial encounter for open fracture
S02.101A	Fracture of base of skull, right side, initial encounter for closed fracture
S02.109A	Fracture of base of skull, unspecified side, initial encounter for closed fracture
S02.102A	Fracture of base of skull, left side, initial encounter for closed fracture
S02.102B	Fracture of base of skull, left side, initial encounter for open fracture
S02.101B	Fracture of base of skull, right side, initial encounter for open fracture
S02.109B	Fracture of base of skull, unspecified side, initial encounter for open fracture
S02.101S	Fracture of base of skull, right side
S02.102S	Fracture of base of skull, left side
S02.109S	Fracture of base of skull, unspecified side
S02.80XA	Fracture of other specified skull and facial bones, unspecified side, initial encounter for closed fracture
S02.81XA	Fracture of other specified skull and facial bones, right side, initial encounter for closed fracture
S02.82XA	Fracture of other specified skull and facial bones, left side, initial encounter for closed fracture
S02.80XB	Fracture of other specified skull and facial bones, unspecified side, initial encounter for open fracture
S02.81XB	Fracture of other specified skull and facial bones, right side, initial encounter for open fracture
S02.82XB	Fracture of other specified skull and facial bones, left side, initial encounter for open fracture
S02.80XD	Fracture of other specified skull and facial bones, unspecified side, subsequent encounter for fracture with routine healing
S02.81XD	Fracture of other specified skull and facial bones, right side, subsequent encounter for fracture with routine healing

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S02.82XD	Fracture of other specified skull and facial bones, left side, subsequent encounter for fracture with routine healing
S02.80XG	Fracture of other specified skull and facial bones, unspecified side, subsequent encounter for fracture with delayed healing
S02.81XG	Fracture of other specified skull and facial bones, right side, subsequent encounter for fracture with delayed healing
S02.82XG	Fracture of other specified skull and facial bones, left side, subsequent encounter for fracture with delayed healing
S02.80XK	Fracture of other specified skull and facial bones, unspecified side, subsequent encounter for fracture with nonunion
S02.81XK	Fracture of other specified skull and facial bones, right side, subsequent encounter for fracture with nonunion
S02.82XK	Fracture of other specified skull and facial bones, left side, subsequent encounter for fracture with nonunion
S02.80XS	Fracture of other specified skull and facial bones, unspecified side, sequela
S02.81XS	Fracture of other specified skull and facial bones, right side, sequela
S02.82XS	Fracture of other specified skull and facial bones, left side, sequela
S02.110A	Type I occipital condyle fracture, initial encounter for closed fracture
S02.110B	Type I occipital condyle fracture, initial encounter for open fracture
S02.111A	Type II occipital condyle fracture, initial encounter for closed fracture
S02.111B	Type II occipital condyle fracture, initial encounter for open fracture
S02.112A	Type III occipital condyle fracture, initial encounter for closed fracture
S02.112B	Type III occipital condyle fracture, initial encounter for open fracture
S02.118A	Other fracture of occiput, initial encounter for closed fracture
S02.118B	Other fracture of occiput, initial encounter for open fracture
S02.119A	Unspecified fracture of occiput, initial encounter for closed fracture
S02.19xA	Other fracture of base of skull, initial encounter for closed fracture
S02.19xB	Other fracture of base of skull, initial encounter for open fracture
S02.91xA	Unspecified fracture of skull, initial encounter for closed fracture
S02.91xB	Unspecified fracture of skull, initial encounter for open fracture
S02.92xA	Unspecified fracture of facial bones, initial encounter for closed fracture

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S02.92xB	Unspecified fracture of facial bones, initial encounter for open fracture
S02.92xD	Unspecified fracture of facial bones, subsequent encounter for fracture with routine healing
S02.92xG	Unspecified fracture of facial bones, subsequent encounter for fracture with delayed healing
S02.92xK	Unspecified fracture of facial bones, subsequent encounter for fracture with nonunion
S04.011A	Injury of optic nerve, right eye, initial encounter
S04.011D	Injury of optic nerve, right eye, subsequent encounter
S04.011S	Injury of optic nerve, right eye, sequela
S04.012A	Injury of optic nerve, left eye, initial encounter
S04.012D	Injury of optic nerve, left eye, subsequent encounter
S04.012S	Injury of optic nerve, left eye, sequela
S04.019A	Injury of optic nerve, unspecified eye, initial encounter
S04.019D	Injury of optic nerve, unspecified eye, subsequent encounter
S04.019S	Injury of optic nerve, unspecified eye, sequela
S04.02xA	Injury of optic chiasm, initial encounter
S04.02xD	Injury of optic chiasm, subsequent encounter
S04.02xS	Injury of optic chiasm, sequela
S04.031A	Injury of optic tract and pathways, right eye, initial encounter
S04.031D	Injury of optic tract and pathways, right eye, subsequent encounter
S04.031S	Injury of optic tract and pathways, right eye, sequela
S04.032A	Injury of optic tract and pathways, left eye, initial encounter
S04.032D	Injury of optic tract and pathways, left eye, subsequent encounter
S04.032S	Injury of optic tract and pathways, left eye, sequela
S04.039A	Injury of optic tract and pathways, unspecified eye, initial encounter
S04.039D	Injury of optic tract and pathways, unspecified eye, subsequent encounter
S04.039S	Injury of optic tract and pathways, unspecified eye, sequela
S04.041A	Injury of visual cortex, right eye, initial encounter
S04.041D	Injury of visual cortex, right eye, subsequent encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S04.041S	Injury of visual cortex, right eye, sequela
S04.042A	Injury of visual cortex, left eye, initial encounter
S04.042D	Injury of visual cortex, left eye, subsequent encounter
S04.042S	Injury of visual cortex, left eye, sequela
S04.049A	Injury of visual cortex, unspecified eye, initial encounter
S04.049D	Injury of visual cortex, unspecified eye, subsequent encounter
S04.049S	Injury of visual cortex, unspecified eye, sequela
S04.10xA	Injury of oculomotor nerve, unspecified side, initial encounter
S04.10xD	Injury of oculomotor nerve, unspecified side, subsequent encounter
S04.10xS	Injury of oculomotor nerve, unspecified side, sequela
S04.11xA	Injury of oculomotor nerve, right side, initial encounter
S04.11xD	Injury of oculomotor nerve, right side, subsequent encounter
S04.11xS	Injury of oculomotor nerve, right side, sequela
S04.12xA	Injury of oculomotor nerve, left side, initial encounter
S04.20xA	Injury of trochlear nerve, unspecified side, initial encounter
S04.20xD	Injury of trochlear nerve, unspecified side, subsequent encounter
S04.20xS	Injury of trochlear nerve, unspecified side, sequela
S04.21xA	Injury of trochlear nerve, right side, initial encounter
S04.21xD	Injury of trochlear nerve, right side, subsequent encounter
S04.21xS	Injury of trochlear nerve, right side, sequela
S04.22xA	Injury of trochlear nerve, left side, initial encounter
S04.22xD	Injury of trochlear nerve, left side, subsequent encounter
S04.22xS	Injury of trochlear nerve, left side, sequela
S04.30xA	Injury of trigeminal nerve, unspecified side, initial encounter
S04.30xD	Injury of trigeminal nerve, unspecified side, subsequent encounter
S04.30xS	Injury of trigeminal nerve, unspecified side, sequela
S04.31xA	Injury of trigeminal nerve, right side, initial encounter
S04.31xD	Injury of trigeminal nerve, right side, subsequent encounter
S04.31xS	Injury of trigeminal nerve, right side, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S04.32xA	Injury of trigeminal nerve, left side, initial encounter
S04.32xD	Injury of trigeminal nerve, left side, subsequent encounter
S04.32xS	Injury of trigeminal nerve, left side, sequela
S04.40xA	Injury of abducent nerve, unspecified side, initial encounter
S04.40xD	Injury of abducent nerve, unspecified side, subsequent encounter
S04.40xS	Injury of abducent nerve, unspecified side, sequela
S04.41xA	Injury of abducent nerve, right side, initial encounter
S04.41xD	Injury of abducent nerve, right side, subsequent encounter
S04.41xS	Injury of abducent nerve, right side, sequela
S04.42xA	Injury of abducent nerve, left side, initial encounter
S04.42xD	Injury of abducent nerve, left side, subsequent encounter
S04.42xS	Injury of abducent nerve, left side, sequela
S04.50xA	Injury of facial nerve, unspecified side, initial encounter
S04.50xD	Injury of facial nerve, unspecified side, subsequent encounter
S04.50xS	Injury of facial nerve, unspecified side, sequela
S04.51xA	Injury of facial nerve, right side, initial encounter
S04.51xD	Injury of facial nerve, right side, subsequent encounter
S04.51xS	Injury of facial nerve, right side, sequela
S04.52xA	Injury of facial nerve, left side, initial encounter
S04.52xD	Injury of facial nerve, left side, subsequent encounter
S04.52xS	Injury of facial nerve, left side, sequela
S04.60xD	Injury of acoustic nerve, unspecified side, subsequent encounter
S04.60xS	Injury of acoustic nerve, unspecified side, sequela
S04.61xA	Injury of acoustic nerve, right side, initial encounter
S04.61xD	Injury of acoustic nerve, right side, subsequent encounter
S04.61xS	Injury of acoustic nerve, right side, sequela
S04.62xA	Injury of acoustic nerve, left side, initial encounter
S04.62xD	Injury of acoustic nerve, left side, subsequent encounter
S04.62xS	Injury of acoustic nerve, left side, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S04.70xA	Injury of accessory nerve, unspecified side, initial encounter
S04.70xD	Injury of accessory nerve, unspecified side, subsequent encounter
S04.70xS	Injury of accessory nerve, unspecified side, sequela
S04.71xA	Injury of accessory nerve, right side, initial encounter
S04.71xD	Injury of accessory nerve, right side, subsequent encounter
S04.71xS	Injury of accessory nerve, right side, sequela
S04.72xA	Injury of accessory nerve, left side, initial encounter
S04.72xD	Injury of accessory nerve, left side, subsequent encounter
S04.72xS	Injury of accessory nerve, left side, sequela
S04.811A	Injury of olfactory [1st] nerve, right side, initial encounter
S04.811D	Injury of olfactory [1st] nerve, right side, subsequent encounter
S04.811S	Injury of olfactory [1st] nerve, right side, sequela
S04.812A	Injury of olfactory [1st] nerve, left side, initial encounter
S04.812D	Injury of olfactory [1st] nerve, left side, subsequent encounter
S04.812S	Injury of olfactory [1st] nerve, left side, sequela
S04.819A	Injury of olfactory [1st] nerve, unspecified side, initial encounter
S04.819D	Injury of olfactory [1st] nerve, unspecified side, subsequent encounter
S04.819S	Injury of olfactory [1st] nerve, unspecified side, sequela
S04.891A	Injury of other cranial nerves, right side, initial encounter
S04.891D	Injury of other cranial nerves, right side, subsequent encounter
S04.891S	Injury of other cranial nerves, right side, sequela
S04.892A	Injury of other cranial nerves, left side, initial encounter
S04.892D	Injury of other cranial nerves, left side, subsequent encounter
S04.892S	Injury of other cranial nerves, left side, sequela
S04.899A	Injury of other cranial nerves, unspecified side, initial encounter
S04.899D	Injury of other cranial nerves, unspecified side, subsequent encounter
S04.899S	Injury of other cranial nerves, unspecified side, sequela
S04.9xxA	Injury of unspecified cranial nerve, initial encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S04.9xxD	Injury of unspecified cranial nerve, subsequent encounter
S04.9xxS	Injury of unspecified cranial nerve, sequela
S05.40xA	Penetrating wound of orbit with or without foreign body, unspecified eye, initial encounter
S05.40xD	Penetrating wound of orbit with or without foreign body, unspecified eye, subsequent encounter
S05.40xS	Penetrating wound of orbit with or without foreign body, unspecified eye, sequela
S05.41xA	Penetrating wound of orbit with or without foreign body, right eye, initial encounter
S05.42xA	Penetrating wound of orbit with or without foreign body, left eye, initial encounter
S05.50xA	Penetrating wound with foreign body of unspecified eyeball, initial encounter
S05.50xD	Penetrating wound with foreign body of unspecified eyeball, subsequent encounter
S05.50xS	Penetrating wound with foreign body of unspecified eyeball, sequela
S05.51xA	Penetrating wound with foreign body of right eyeball, initial encounter
S05.51xD	Penetrating wound with foreign body of right eyeball, subsequent encounter
S05.51xS	Penetrating wound with foreign body of right eyeball, sequela
S05.52xA	Penetrating wound with foreign body of left eyeball, initial encounter
S05.52xD	Penetrating wound with foreign body of left eyeball, subsequent encounter
S05.52xS	Penetrating wound with foreign body of left eyeball, sequela
S06.A0XA	Traumatic brain compression without herniation, init
S06.A0XD	Traumatic brain compression without herniation, subs
S06.A0XS	Traumatic brain compression without herniation, sequela
S06.A1XA	Traumatic brain compression with herniation, init
S06.A1XD	Traumatic brain compression with herniation, subs
S06.A1XS	Traumatic brain compression with herniation, sequela
S06.0X0A	Concussion without loss of consciousness, initial encounter
S06.0X0D	Concussion without loss of consciousness, subsequent encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.0X0S	Concussion without loss of consciousness, sequela
S06.0X1A	Concussion with loss of consciousness of 30 minutes or less, initial encounter
S06.0X1D	Concussion with loss of consciousness of 30 minutes or less, subsequent encounter
S06.0X1S	Concussion with loss of consciousness of 30 minutes or less, sequela
S06.0X2A	Concussion with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.0X2D	Concussion with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter
S06.0X2S	Concussion with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.0X9A	Concussion with loss of consciousness of unspecified duration, initial encounter
S06.0X9D	Concussion with loss of consciousness of unspecified duration, subsequent encounter
S06.0X9S	Concussion with loss of consciousness of unspecified duration, sequela
S06.2X6D	Diffuse traumatic brain injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent encounter
S06.310A	Contusion and laceration of right cerebrum without loss of consciousness, initial encounter
S06.310D	Contusion and laceration of right cerebrum without loss of consciousness, subsequent 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
S06.311D	Contusion and laceration of right cerebrum with loss of consciousness of 30 minutes or less, subsequent 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
S06.312D	Contusion and laceration of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
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
S06.313D	Contusion and laceration of right cerebrum with loss of consciousness of 1 hour to 5 hours 59 minutes, subsequent 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
S06.314D	Contusion and laceration of right cerebrum with loss of consciousness of 6 hours to 24 hours, subsequent 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
S06.315D	Contusion and laceration of right cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, subsequent 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
S06.316D	Contusion and laceration of right cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent 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
S06.319D	Contusion and laceration of right cerebrum with loss of consciousness of unspecified duration, subsequent encounter
S06.319S	Contusion and laceration of right cerebrum with loss of consciousness of unspecified duration, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.320A	Contusion and laceration of left cerebrum without loss of consciousness, initial encounter
S06.320D	Contusion and laceration of left cerebrum without loss of consciousness, subsequent 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
S06.321D	Contusion and laceration of left cerebrum with loss of consciousness of 30 minutes or less, subsequent 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
S06.322D	Contusion and laceration of left cerebrum with loss of consciousness of 31 minutes to 59 minutes, subsequent 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
S06.323D	Contusion and laceration of left cerebrum with loss of consciousness of 1 hour to 5 hours 59 minutes, subsequent 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
S06.324D	Contusion and laceration of left cerebrum with loss of consciousness of 6 hours to 24 hours, subsequent 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
S06.325D	Contusion and laceration of left cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, subsequent encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
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
S06.326D	Contusion and laceration of left cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent 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
S06.329D	Contusion and laceration of left cerebrum with loss of consciousness of unspecified duration, subsequent 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
S06.330D	Contusion and laceration of cerebrum, unspecified, without loss of consciousness, subsequent encounter
S06.330S	Contusion and laceration of cerebrum, unspecified, without loss of consciousness, sequela
S06.331A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, initial encounter
S06.331D	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, subsequent 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
S06.332D	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 31 minutes to 59 minutes, subsequent 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

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.333D	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 1 hour to 5 hours 59 minutes, subsequent 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
S06.334D	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 6 hours to 24 hours, subsequent 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
S06.335D	Contusion and laceration of cerebrum, unspecified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, subsequent 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
S06.336D	Contusion and laceration of cerebrum, unspecified, with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent 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
S06.340A	Traumatic hemorrhage of right cerebrum without loss of consciousness, initial encounter
S06.340D	Traumatic hemorrhage of right cerebrum without loss of consciousness, subsequent encounter
S06.340S	Traumatic hemorrhage of right cerebrum without loss of consciousness, sequela
S06.341A	Traumatic hemorrhage of right cerebrum with loss of consciousness of 30 minutes or less, initial encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.341D	Traumatic hemorrhage of right cerebrum with loss of consciousness of 30 minutes or less, subsequent encounter
S06.341S	Traumatic hemorrhage of right cerebrum with loss of consciousness of 30 minutes or less, sequela
S06.342A	Traumatic hemorrhage of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.342D	Traumatic hemorrhage of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter
S06.342S	Traumatic hemorrhage of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.343A	Traumatic hemorrhage of right cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, initial encounter
S06.343D	Traumatic hemorrhage of right cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, subsequent encounter
S06.343S	Traumatic hemorrhage of right cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, sequela
S06.344A	Traumatic hemorrhage of right cerebrum with loss of consciousness hours, initial encounter
S06.344D	Traumatic hemorrhage of right cerebrum with loss of consciousness of 6 hours to 24 hours, subsequent encounter
S06.344S	Traumatic hemorrhage of right cerebrum with loss of consciousness of 6 hours to 24 hours, sequela
S06.345A	Traumatic hemorrhage of right cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.345D	Traumatic hemorrhage of right cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, subsequent encounter
S06.345S	Traumatic hemorrhage of right cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.346A	Traumatic hemorrhage of right cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.346D	Traumatic hemorrhage of right cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
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
S06.349A	Traumatic hemorrhage of right cerebrum with loss of consciousness of unspecified duration, initial encounter
S06.349D	Traumatic hemorrhage of right cerebrum with loss of consciousness of unspecified duration, subsequent encounter
S06.349S	Traumatic hemorrhage of right cerebrum with loss of consciousness of unspecified duration, sequela
S06.350A	Traumatic hemorrhage of left cerebrum without loss of consciousness, initial encounter
S06.351A	Traumatic hemorrhage of left cerebrum with loss of consciousness of 30 minutes or less, initial encounter
S06.351D	Traumatic hemorrhage of left cerebrum with loss of consciousness of 30 minutes or less, subsequent encounter
S06.351S	Traumatic hemorrhage of left cerebrum with loss of consciousness of 30 minutes or less, sequela
S06.352A	Traumatic hemorrhage of left cerebrum with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.352D	Traumatic hemorrhage of left cerebrum with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter
S06.352S	Traumatic hemorrhage of left cerebrum with loss of consciousness of, sequela
S06.353A	Traumatic hemorrhage of left cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, initial encounter
S06.353D	Traumatic hemorrhage of left cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, subsequent encounter
S06.353S	Traumatic hemorrhage of left cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, sequela
S06.354A	Traumatic hemorrhage of left cerebrum with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.354D	Traumatic hemorrhage of left cerebrum with loss of consciousness of 6 hours to 24 hours, subsequent encounter
S06.354S	Traumatic hemorrhage of left cerebrum with loss of consciousness of 6 hours to 24 hours, sequela
S06.355A	Traumatic hemorrhage of left cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.355D	Traumatic hemorrhage of left cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, subsequent encounter
S06.355S	Traumatic hemorrhage of left cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.356A	Traumatic hemorrhage of left cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.356D	Traumatic hemorrhage of left cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent encounter
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
S06.359A	Traumatic hemorrhage of left cerebrum with loss of consciousness of unspecified duration, initial encounter
S06.359D	Traumatic hemorrhage of left cerebrum with loss of consciousness of unspecified duration, subsequent encounter
S06.359S	Traumatic hemorrhage of left cerebrum with loss of consciousness of unspecified duration, sequela
S06.360A	Traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, initial encounter
S06.360D	Traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, subsequent encounter
S06.360S	Traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, sequela
S06.361A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, initial encounter
S06.361D	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, subsequent encounter
S06.361S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, sequela
S06.362A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.362D	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter
S06.362S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 31 minutes to 59 minutes, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.363A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 1 hours to 5 hours 59 minutes, initial encounter
S06.363D	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 1 hours to 5 hours 59 minutes, subsequent encounter
S06.363S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 1 hours to 5 hours 59 minutes, sequela
S06.364A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.364D	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 6 hours to 24 hours, subsequent encounter
S06.364S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 6 hours to 24 hours, sequela
S06.365A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.365D	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, subsequent encounter
S06.365S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.366A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.366D	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent encounter
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, sequela
S06.367A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter
S06.368A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter
S06.369A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of unspecified duration, initial encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.369D	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of unspecified duration, subsequent encounter
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
S06.370D	Contusion, laceration, and hemorrhage of cerebellum without loss of consciousness, subsequent 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
S06.371D	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 30 minutes or less, subsequent 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
S06.372D	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 31 minutes to 59 minutes, subsequent 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
S06.373D	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 1 hour to 5 hours 59 minutes, subsequent 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
S06.374D	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 6 hours to 24 hours, subsequent 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 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.375D	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness greater than 24 hours with return to pre- existing conscious level, subsequent encounter
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
S06.376D	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent 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
S06.379D	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of unspecified duration, subsequent encounter
S06.379S	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of unspecified duration, sequela
S06.380A	Contusion, laceration, and hemorrhage of brainstem without loss of consciousness, initial encounter
S06.380D	Contusion, laceration, and hemorrhage of brainstem without loss of consciousness, subsequent 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
S06.381D	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 30 minutes or less, subsequent 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
S06.382D	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter
S06.382S	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 31 minutes to 59 minutes, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.383A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.383D	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 1 hour to 5 hours 59 minutes, subsequent 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
S06.384D	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 6 hours to 24 hours, subsequent 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
S06.385D	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness greater than 24 hours with return to pre-existing conscious level, subsequent 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
S06.386D	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent 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
S06.389D	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of unspecified duration, subsequent encounter
S06.389S	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of unspecified duration, sequela
S06.4X0A	Epidural hemorrhage without loss of consciousness, initial encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.4X0D	Epidural hemorrhage without loss of consciousness, subsequent encounter
S06.4X0S	Epidural hemorrhage without loss of consciousness, sequela
S06.4X1A	Epidural hemorrhage with loss of consciousness of 30 minutes or less, initial encounter
S06.4X1D	Epidural hemorrhage with loss of consciousness of 30 minutes or less, subsequent encounter
S06.4X1S	Epidural hemorrhage with loss of consciousness of 30 minutes or less, sequela
S06.4X2A	Epidural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.4X2D	Epidural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter
S06.4X2S	Epidural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.4X3A	Epidural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.4X3D	Epidural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, subsequent encounter
S06.4X3S	Epidural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.4X4A	Epidural hemorrhage with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.4X4D	Epidural hemorrhage with loss of consciousness of 6 hours to 24 hours, subsequent encounter
S06.4X4S	Epidural hemorrhage with loss of consciousness of 6 hours to 24 hours, sequela
S06.4X5A	Epidural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.4X5D	Epidural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, subsequent encounter
S06.4X5S	Epidural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.4X6A	Epidural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.4X6D	Epidural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent encounter
S06.4X6S	Epidural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.4X9A	Epidural hemorrhage with loss of consciousness of unspecified duration, initial encounter
S06.4X9D	Epidural hemorrhage with loss of consciousness of unspecified duration, subsequent encounter
S06.4X9S	Epidural hemorrhage with loss of consciousness of unspecified duration, sequela
S06.5X0A	Traumatic subdural hemorrhage without loss of consciousness, initial encounter
S06.5X0D	Traumatic subdural hemorrhage without loss of consciousness, subsequent encounter
S06.5X0S	Traumatic subdural hemorrhage without loss of consciousness, sequela
S06.5X1A	Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, initial encounter
S06.5X1D	Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, subsequent encounter
S06.5X1S	Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, sequela
S06.5X2A	Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.5X2D	Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter
S06.5X2S	Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.5X3A	Traumatic subdural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.5X3D	Traumatic subdural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, subsequent encounter
S06.5X3S	Traumatic subdural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.5X4A	Traumatic subdural hemorrhage with loss of consciousness of 6 hours to 24 hours, initial encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.5X4D	Traumatic subdural hemorrhage with loss of consciousness of 6 hours to 24 hours, subsequent encounter
S06.5X4S	Traumatic subdural hemorrhage with loss of consciousness of 6 hours to 24 hours, sequela
S06.5X5A	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.5X5D	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, subsequent encounter
S06.5X5S	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.5X6A	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.5X6D	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent encounter
S06.5X6S	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.5X9A	Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, initial encounter
S06.5X9D	Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, subsequent encounter
S06.5X9S	Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, sequela
S06.6X0A	Traumatic subarachnoid hemorrhage without loss of consciousness, initial encounter
S06.6X0D	Traumatic subarachnoid hemorrhage without loss of consciousness, subsequent encounter
S06.6X0S	Traumatic subarachnoid hemorrhage without loss of consciousness, sequela
S06.6X1A	Traumatic subarachnoid hemorrhage with loss of consciousness of 30 minutes or less, initial encounter
S06.6X1D	Traumatic subarachnoid hemorrhage with loss of consciousness of 30 minutes or less, subsequent encounter
S06.6X1S	Traumatic subarachnoid hemorrhage with loss of consciousness of 30 minutes or less, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.6X2A	Traumatic subarachnoid hemorrhage with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.6X2D	Traumatic subarachnoid hemorrhage with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter
S06.6X2S	Traumatic subarachnoid hemorrhage with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.6X3A	Traumatic subarachnoid hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.6X3D	Traumatic subarachnoid hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, subsequent encounter
S06.6X3S	Traumatic subarachnoid hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.6X4A	Traumatic subarachnoid hemorrhage with loss of consciousness of 6 hours to 24 hours, initial encounter
S06.6X4D	Traumatic subarachnoid hemorrhage with loss of consciousness of 6 hours to 24 hours, subsequent encounter
S06.6X4S	Traumatic subarachnoid hemorrhage with loss of consciousness of 6 hours to 24 hours, sequela
S06.6X5A	Traumatic subarachnoid hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.6X5S	Traumatic subarachnoid hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.6X6A	Traumatic subarachnoid hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter
S06.6X9A	Traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, initial encounter
S06.6X9D	Traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, subsequent encounter
S06.6X9S	Traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, sequela
S06.890A	Other specified intracranial injury without loss of consciousness, initial encounter
S06.890D	Other specified intracranial injury without loss of consciousness, subsequent encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
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
S06.891D	Other specified intracranial injury with loss of consciousness of 30 minutes or less, subsequent 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
S06.892D	Other specified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, subsequent 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
S06.893D	Other specified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, subsequent 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
S06.895A	Other specified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
S06.895D	Other specified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, subsequent 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
S06.896D	Other specified intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent 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

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.899A	Other specified intracranial injury with loss of consciousness of unspecified duration, initial encounter
S06.899D	Other specified intracranial injury with loss of consciousness of unspecified duration, subsequent 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
S06.9X0D	Unspecified intracranial injury without loss of consciousness, subsequent 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
S06.9X1D	Unspecified intracranial injury with loss of consciousness of 30 minutes or less, subsequent encounter
S06.9X1S	Unspecified intracranial injury with loss of consciousness of 30 minutes or less, sequela
S06.9X2A	Unspecified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.9X2D	Unspecified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, subsequent 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
S06.9X3D	Unspecified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, subsequent encounter
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
S06.9X4D	Unspecified intracranial injury with loss of consciousness of 6 hours to 24 hours, subsequent encounter
S06.9X4S	Unspecified intracranial injury with loss of consciousness of 6 hours to 24 hours, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S06.9X5A	Unspecified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter
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
S06.9X6D	Unspecified intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, subsequent 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
S06.9X9D	Unspecified intracranial injury with loss of consciousness of unspecified duration, subsequent encounter
S06.9X9S	Unspecified intracranial injury with loss of consciousness of unspecified duration, sequela
S09.90xA	Unspecified injury of head, initial encounter
S09.90xD	Unspecified injury of head, subsequent encounter
S09.90xS	Unspecified injury of head, sequela
S14.0xxA	Concussion and edema of cervical spinal cord, initial encounter
S14.101A	Unspecified injury at C1 level of cervical spinal cord, initial encounter
S14.101D	Unspecified injury at C1 level of cervical spinal cord, subsequent encounter
S14.101S	Unspecified injury at C1 level of cervical spinal cord, sequela
S14.102A	Unspecified injury at C2 level of cervical spinal cord, initial encounter
S14.102D	Unspecified injury at C2 level of cervical spinal cord, subsequent encounter
S14.102S	Unspecified injury at C2 level of cervical spinal cord, sequela
S14.103A	Unspecified injury at C3 level of cervical spinal cord, initial encounter
S14.103D	Unspecified injury at C3 level of cervical spinal cord, subsequent encounter
S14.103S	Unspecified injury at C3 level of cervical spinal cord, sequela
S14.104A	Unspecified injury at C4 level of cervical spinal cord, initial encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S14.104D	Unspecified injury at C4 level of cervical spinal cord, subsequent encounter
S14.104S	Unspecified injury at C4 level of cervical spinal cord, sequela
S14.105A	Unspecified injury at C5 level of cervical spinal cord, initial encounter
S14.105D	Unspecified injury at C5 level of cervical spinal cord, subsequent encounter
S14.105S	Unspecified injury at C5 level of cervical spinal cord, sequela
S14.106A	Unspecified injury at C6 level of cervical spinal cord, initial encounter
S14.106D	Unspecified injury at C6 level of cervical spinal cord, subsequent encounter
S14.106S	Unspecified injury at C6 level of cervical spinal cord, sequela
S14.107A	Unspecified injury at C7 level of cervical spinal cord, initial encounter
S14.107D	Unspecified injury at C7 level of cervical spinal cord, subsequent encounter
S14.107S	Unspecified injury at C7 level of cervical spinal cord, sequela
S14.109A	Unspecified injury at unspecified level of cervical spinal cord, initial encounter
S14.109D	Unspecified injury at unspecified level of cervical spinal cord, subsequent encounter
S14.111A	Complete lesion at C1 level of cervical spinal cord, initial encounter
S14.111D	Complete lesion at C1 level of cervical spinal cord, subsequent encounter
S14.111S	Complete lesion at C1 level of cervical spinal cord, sequela
S14.112A	Complete lesion at C2 level of cervical spinal cord, initial encounter
S14.112D	Complete lesion at C2 level of cervical spinal cord, subsequent encounter
S14.112S	Complete lesion at C2 level of cervical spinal cord, sequela
S14.113A	Complete lesion at C3 level of cervical spinal cord, initial encounter
S14.113S	Complete lesion at C3 level of cervical spinal cord, sequela
S14.114A	Complete lesion at C4 level of cervical spinal cord, initial encounter
S14.114D	Complete lesion at C4 level of cervical spinal cord, subsequent encounter
S14.114S	Complete lesion at C4 level of cervical spinal cord, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S14.115A	Complete lesion at C5 level of cervical spinal cord, initial encounter
S14.115D	Complete lesion at C5 level of cervical spinal cord, subsequent encounter
S14.115S	Complete lesion at C5 level of cervical spinal cord, sequela
S14.116A	Complete lesion at C6 level of cervical spinal cord, initial encounter
S14.116D	Complete lesion at C6 level of cervical spinal cord, subsequent encounter
S14.116S	Complete lesion at C6 level of cervical spinal cord, sequela
S14.117A	Complete lesion at C7 level of cervical spinal cord, initial encounter
S14.117D	Complete lesion at C7 level of cervical spinal cord, subsequent encounter
S14.117S	Complete lesion at C7 level of cervical spinal cord, sequela
S14.119A	Complete lesion at unspecified level of cervical spinal cord, initial encounter
S14.121A	Central cord syndrome at C1 level of cervical spinal cord, initial encounter
S14.121D	Central cord syndrome at C1 level of cervical spinal cord, subsequent encounter
S14.121S	Central cord syndrome at C1 level of cervical spinal cord, sequela
S14.122A	Central cord syndrome at C2 level of cervical spinal cord, initial encounter
S14.122D	Central cord syndrome at C2 level of cervical spinal cord, subsequent encounter
S14.122S	Central cord syndrome at C2 level of cervical spinal cord, sequela
S14.123A	Central cord syndrome at C3 level of cervical spinal cord, initial encounter
S14.123D	Central cord syndrome at C3 level of cervical spinal cord, subsequent encounter
S14.123S	Central cord syndrome at C3 level of cervical spinal cord, sequela
S14.124A	Central cord syndrome at C4 level of cervical spinal cord, initial encounter
S14.124D	Central cord syndrome at C4 level of cervical spinal cord, subsequent encounter
S14.124S	Central cord syndrome at C4 level of cervical spinal cord, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S14.125A	Central cord syndrome at C5 level of cervical spinal cord, initial encounter
S14.125D	Central cord syndrome at C5 level of cervical spinal cord, subsequent encounter
S14.125S	Central cord syndrome at C5 level of cervical spinal cord, sequela
S14.126A	Central cord syndrome at C6 level of cervical spinal cord, initial encounter
S14.126D	Central cord syndrome at C6 level of cervical spinal cord, subsequent encounter
S14.126S	Central cord syndrome at C6 level of cervical spinal cord, sequela
S14.127A	Central cord syndrome at C7 level of cervical spinal cord, initial encounter
S14.127D	Central cord syndrome at C7 level of cervical spinal cord, subsequent encounter
S14.127S	Central cord syndrome at C7 level of cervical spinal cord, sequela
S14.129A	Central cord syndrome at unspecified level of cervical spinal cord, initial encounter
S14.131A	Anterior cord syndrome at C1 level of cervical spinal cord, initial encounter
S14.131D	Anterior cord syndrome at C1 level of cervical spinal cord, subsequent encounter
S14.131S	Anterior cord syndrome at C1 level of cervical spinal cord, sequela
S14.132A	Anterior cord syndrome at C2 level of cervical spinal cord, initial encounter
S14.132D	Anterior cord syndrome at C2 level of cervical spinal cord, subsequent encounter
S14.132S	Anterior cord syndrome at C2 level of cervical spinal cord, sequela
S14.133A	Anterior cord syndrome at C3 level of cervical spinal cord, initial encounter
S14.133S	Anterior cord syndrome at C3 level of cervical spinal cord, sequela
S14.134A	Anterior cord syndrome at C4 level of cervical spinal cord, initial encounter
S14.134D	Anterior cord syndrome at C4 level of cervical spinal cord, subsequent encounter
S14.134S	Anterior cord syndrome at C4 level of cervical spinal cord, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S14.135A	Anterior cord syndrome at C5 level of cervical spinal cord, initial encounter
S14.135D	Anterior cord syndrome at C5 level of cervical spinal cord, subsequent encounter
S14.135S	Anterior cord syndrome at C5 level of cervical spinal cord, sequela
S14.136A	Anterior cord syndrome at C6 level of cervical spinal cord, initial encounter
S14.136D	Anterior cord syndrome at C6 level of cervical spinal cord, subsequent encounter
S14.136S	Anterior cord syndrome at C6 level of cervical spinal cord, sequela
S14.137A	Anterior cord syndrome at C7 level of cervical spinal cord, initial encounter
S14.137D	Anterior cord syndrome at C7 level of cervical spinal cord, subsequent encounter
S14.137S	Anterior cord syndrome at C7 level of cervical spinal cord, sequela
S14.138A	Anterior cord syndrome at C8 level of cervical spinal cord, initial encounter
S14.139A	Anterior cord syndrome at unspecified level of cervical spinal cord, initial encounter
S14.141A	Brown-Sequard syndrome at C1 level of cervical spinal cord, initial encounter
S14.142A	Brown-Sequard syndrome at C2 level of cervical spinal cord, initial encounter
S14.143A	Brown-Sequard syndrome at C3 level of cervical spinal cord, initial encounter
S14.144A	Brown-Sequard syndrome at C4 level of cervical spinal cord, initial encounter
S14.145A	Brown-Sequard syndrome at C5 level of cervical spinal cord, initial encounter
S14.146A	Brown-Sequard syndrome at C6 level of cervical spinal cord, initial encounter
S14.147A	Brown-Sequard syndrome at C7 level of cervical spinal cord, initial encounter
S14.149A	Brown-Sequard syndrome at unspecified level of cervical spinal cord, initial encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S14.149D	Brown-Sequard syndrome at unspecified level of cervical spinal cord, subsequent encounter
S14.149S	Brown-Sequard syndrome at unspecified level of cervical spinal cord, sequela
S14.151A	Other incomplete lesion at C1 level of cervical spinal cord, initial encounter
S14.152A	Other incomplete lesion at C2 level of cervical spinal cord, initial encounter
S14.153A	Other incomplete lesion at C3 level of cervical spinal cord, initial encounter
S14.154A	Other incomplete lesion at C4 level of cervical spinal cord, initial encounter
S14.155A	Other incomplete lesion at C5 level of cervical spinal cord, initial encounter
S14.156A	Other incomplete lesion at C6 level of cervical spinal cord, initial encounter
S14.157A	Other incomplete lesion at C7 level of cervical spinal cord, initial encounter
S14.158A	Other incomplete lesion at C8 level of cervical spinal cord, initial encounter
S14.159A	Other incomplete lesion at unspecified level of cervical spinal cord, initial encounter
S24.101A	Unspecified injury at T1 level of thoracic spinal cord, initial encounter
S24.101D	Unspecified injury at T1 level of thoracic spinal cord, subsequent encounter
S24.101S	Unspecified injury at T1 level of thoracic spinal cord, sequela
S24.102A	Unspecified injury at T2-T6 level of thoracic spinal cord, initial encounter
S24.102D	Unspecified injury at T2-T6 level of thoracic spinal cord, subsequent encounter
S24.102S	Unspecified injury at T2-T6 level of thoracic spinal cord, sequela
S24.103A	Unspecified injury at T7-T10 level of thoracic spinal cord, initial encounter
S24.103D	Unspecified injury at T7-T10 level of thoracic spinal cord, subsequent encounter
S24.103S	Unspecified injury at T7-T10 level of thoracic spinal cord, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S24.104A	Unspecified injury at T11-T12 level of thoracic spinal cord, initial encounter
S24.104D	Unspecified injury at T11-T12 level of thoracic spinal cord, subsequent encounter
S24.104S	Unspecified injury at T11-T12 level of thoracic spinal cord, sequela
S24.109A	Unspecified injury at unspecified level of thoracic spinal cord, initial encounter
S24.109D	Unspecified injury at unspecified level of thoracic spinal cord, subsequent encounter
S24.111A	Complete lesion at T1 level of thoracic spinal cord, initial encounter
S24.111D	Complete lesion at T1 level of thoracic spinal cord, subsequent encounter
S24.111S	Complete lesion at T1 level of thoracic spinal cord, sequela
S24.112A	Complete lesion at T2-T6 level of thoracic spinal cord, initial encounter
S24.112D	Complete lesion at T2-T6 level of thoracic spinal cord, subsequent encounter
S24.112S	Complete lesion at T2-T6 level of thoracic spinal cord, sequela
S24.113A	Complete lesion at T7-T10 level of thoracic spinal cord, initial encounter
S24.113D	Complete lesion at T7-T10 level of thoracic spinal cord, subsequent encounter
S24.113S	Complete lesion at T7-T10 level of thoracic spinal cord, sequela
S24.114A	Complete lesion at T11-T12 level of thoracic spinal cord, initial encounter
S24.114D	Complete lesion at T11-T12 level of thoracic spinal cord, subsequent encounter
S24.114S	Complete lesion at T11-T12 level of thoracic spinal cord, sequela
S24.119A	Complete lesion at unspecified level of thoracic spinal cord, initial encounter
S24.131A	Anterior cord syndrome at T1 level of thoracic spinal cord, initial encounter
S24.131D	Anterior cord syndrome at T1 level of thoracic spinal cord, subsequent encounter
S24.131S	Anterior cord syndrome at T1 level of thoracic spinal cord, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S24.132A	Anterior cord syndrome at T2-T6 level of thoracic spinal cord, initial encounter
S24.132D	Anterior cord syndrome at T2-T6 level of thoracic spinal cord, subsequent encounter
S24.132S	Anterior cord syndrome at T2-T6 level of thoracic spinal cord, sequela
S24.133A	Anterior cord syndrome at T7-T10 level of thoracic spinal cord, initial encounter
S24.133D	Anterior cord syndrome at T7-T10 level of thoracic spinal cord, subsequent encounter
S24.133S	Anterior cord syndrome at T7-T10 level of thoracic spinal cord, sequela
S24.134A	Anterior cord syndrome at T11-T12 level of thoracic spinal cord, initial encounter
S24.134D	Anterior cord syndrome at T11-T12 level of thoracic spinal cord, subsequent encounter
S24.134S	Anterior cord syndrome at T11-T12 level of thoracic spinal cord, sequela
S24.139A	Anterior cord syndrome at unspecified level of thoracic spinal cord, initial encounter
S24.141A	Brown-Sequard syndrome at T1 level of thoracic spinal cord, initial encounter
S24.141S	Brown-Sequard syndrome at T1 level of thoracic spinal cord, sequela
S24.142A	Brown-Sequard syndrome at T2-T6 level of thoracic spinal cord, initial encounter
S24.142S	Brown-Sequard syndrome at T2-T6 level of thoracic spinal cord, sequela
S24.143A	Brown-Sequard syndrome at T7-T10 level of thoracic spinal cord, initial encounter
S24.143S	Brown-Sequard syndrome at T7-T10 level of thoracic spinal cord, sequela
S24.144A	Brown-Sequard syndrome at T11-T12 level of thoracic spinal cord, initial encounter
S24.144S	Brown-Sequard syndrome at T11-T12 level of thoracic spinal cord, sequela
S24.149A	Brown-Sequard syndrome at unspecified level of thoracic spinal cord, initial encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S24.149D	Brown-Sequard syndrome at unspecified level of thoracic spinal cord, subsequent encounter
S24.149S	Brown-Sequard syndrome at unspecified level of thoracic spinal cord, sequela
S24.151A	Other incomplete lesion at T1 level of thoracic spinal cord, initial encounter
S24.151D	Other incomplete lesion at T1 level of thoracic spinal cord, subsequent encounter
S24.151S	Other incomplete lesion at T1 level of thoracic spinal cord, sequela
S24.152A	Other incomplete lesion at T2-T6 level of thoracic spinal cord, initial encounter
S24.152D	Other incomplete lesion at T2-T6 level of thoracic spinal cord, subsequent encounter
S24.152S	Other incomplete lesion at T2-T6 level of thoracic spinal cord, sequela
S24.153A	Other incomplete lesion at T7-T10 level of thoracic spinal cord, initial encounter
S24.153D	Other incomplete lesion at T7-T10 level of thoracic spinal cord, subsequent encounter
S24.153S	Other incomplete lesion at T7-T10 level of thoracic spinal cord, sequela
S24.154A	Other incomplete lesion at T11-T12 level of thoracic spinal cord, initial encounter
S24.154D	Other incomplete lesion at T11-T12 level of thoracic spinal cord, subsequent encounter
S24.154S	Other incomplete lesion at T11-T12 level of thoracic spinal cord, sequela
S24.159A	Other incomplete lesion at unspecified level of thoracic spinal cord, initial encounter
S34.01xA	Concussion and edema of lumbar spinal cord, initial encounter
S34.02xA	Concussion and edema of sacral spinal cord, initial encounter
S34.02xD	Concussion and edema of sacral spinal cord, subsequent encounter
S34.02xS	Concussion and edema of sacral spinal cord, sequela
S34.101A	Unspecified injury to L1 level of lumbar spinal cord, initial encounter
S34.101D	Unspecified injury to L1 level of lumbar spinal cord, subsequent encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S34.101S	Unspecified injury to L1 level of lumbar spinal cord, sequela
S34.102A	Unspecified injury to L2 level of lumbar spinal cord, initial encounter
S34.102D	Unspecified injury to L2 level of lumbar spinal cord, subsequent encounter
S34.102S	Unspecified injury to L2 level of lumbar spinal cord, sequela
S34.103A	Unspecified injury to L3 level of lumbar spinal cord, initial encounter
S34.103D	Unspecified injury to L3 level of lumbar spinal cord, subsequent encounter
S34.103S	Unspecified injury to L3 level of lumbar spinal cord, sequela
S34.104A	Unspecified injury to L4 level of lumbar spinal cord, initial encounter
S34.104D	Unspecified injury to L4 level of lumbar spinal cord, subsequent encounter
S34.104S	Unspecified injury to L4 level of lumbar spinal cord, sequela
S34.105A	Unspecified injury to L5 level of lumbar spinal cord, initial encounter
S34.105D	Unspecified injury to L5 level of lumbar spinal cord, subsequent encounter
S34.105S	Unspecified injury to L5 level of lumbar spinal cord, sequela
S34.109A	Unspecified injury to unspecified level of lumbar spinal cord, initial encounter
S34.109S	Unspecified injury to unspecified level of lumbar spinal cord, sequela
S34.111A	Complete lesion of L1 level of lumbar spinal cord, initial encounter
S34.111D	Complete lesion of L1 level of lumbar spinal cord, subsequent encounter
S34.112A	Complete lesion of L2 level of lumbar spinal cord, initial encounter
S34.112D	Complete lesion of L2 level of lumbar spinal cord, subsequent encounter
S34.113A	Complete lesion of L3 level of lumbar spinal cord, initial encounter
S34.113D	Complete lesion of L3 level of lumbar spinal cord, subsequent encounter
S34.114A	Complete lesion of L4 level of lumbar spinal cord, initial encounter
S34.114D	Complete lesion of L4 level of lumbar spinal cord, subsequent encounter
S34.115A	Complete lesion of L5 level of lumbar spinal cord, initial encounter

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S34.115D	Complete lesion of L5 level of lumbar spinal cord, subsequent encounter
S34.119A	Complete lesion of unspecified level of lumbar spinal cord, initial encounter
S34.119D	Complete lesion of unspecified level of lumbar spinal cord, subsequent encounter
S34.121A	Incomplete lesion of L1 level of lumbar spinal cord, initial encounter
S34.121D	Incomplete lesion of L1 level of lumbar spinal cord, subsequent encounter
S34.121S	Incomplete lesion of L1 level of lumbar spinal cord, sequela
S34.122A	Incomplete lesion of L2 level of lumbar spinal cord, initial encounter
S34.122D	Incomplete lesion of L2 level of lumbar spinal cord, subsequent encounter
S34.122S	Incomplete lesion of L2 level of lumbar spinal cord, sequela
S34.123A	Incomplete lesion of L3 level of lumbar spinal cord, initial encounter
S34.123D	Incomplete lesion of L3 level of lumbar spinal cord, subsequent encounter
S34.123S	Incomplete lesion of L3 level of lumbar spinal cord, sequela
S34.124A	Incomplete lesion of L4 level of lumbar spinal cord, initial encounter
S34.124D	Incomplete lesion of L4 level of lumbar spinal cord, subsequent encounter
S34.125A	Incomplete lesion of L5 level of lumbar spinal cord, initial encounter
S34.129A	Incomplete lesion of unspecified level of lumbar spinal cord, initial encounter
S34.131A	Complete lesion of sacral spinal cord, initial encounter
S34.131D	Complete lesion of sacral spinal cord, subsequent encounter
S34.131S	Complete lesion of sacral spinal cord, sequela
S34.132A	Incomplete lesion of sacral spinal cord, initial encounter
S34.132D	Incomplete lesion of sacral spinal cord, subsequent encounter
S34.132S	Incomplete lesion of sacral spinal cord, sequela
S34.139A	Unspecified injury to sacral spinal cord, initial encounter
S34.139D	Unspecified injury to sacral spinal cord, subsequent encounter
S34.139S	Unspecified injury to sacral spinal cord, sequela

ICD-10 CM – Diagnosis Code	ICD-10 CM - Diagnosis Description
S34.3xxA	Injury of cauda equina, initial encounter
S34.3xxD	Injury of cauda equina, subsequent encounter
S34.3xxS	Injury of cauda equina, sequela