COUNCIL FOR MEDICAL SCHEMES

ICD-10 Implementation Review

January 2004 – October 2006

National Task Team On

ICD-10

Implementation

October 2006

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Table of Contents

1. INTRODUCTION

ICD-10[1] is a diagnosis coding standard owned and maintained by the World Health Organisation (WHO). This coding standard was adopted by the National Health Information System of South Africa (NHISSA), and forms part of the health information strategy of the Department of Health. The standard currently serves as the diagnosis coding standard of choice in both the public and private sector.

The purpose of ICD-10 is to translate diagnoses of diseases and other health problems from descriptions into an alphanumeric code, which permits easy storage, retrieval and analysis of the data. It also allows for the establishment of a systematic recording, analysis, interpretation and comparison of morbidity and mortality data collected within the country but also with other countries.

In the South African setting, ICD-10 coding is important in that it lends itself well to the improvement of efficiency of healthcare through appropriate and standardised recording of diagnosis, analysis of information for patient care, research, performance improvement, healthcare planning and facility management. It also enables fair reimbursement for healthcare services provided and communicates health data in a predictable, consistent and reproducible manner.

Only recently have discussions around coding for morbidity begun as the next logical step in the development of a sound health information system for South Africa. In 2000, the Council for Medical Schemes, at the request of the Minister of Health, held consultative meetings with providers and medical schemes in an effort to address concerns raised by healthcare providers with regards to poor payment of claims submitted on behalf of medical scheme beneficiaries. At the core of the problem was the need for greater standardisation of data collection, IT systems, and billing practices.

A process to standardise data and billing practices in the industry was started in 2001 with the formation of a Committee on Standardisation of Data and Billing practices. The Committee sought to address some of the concerns raised by providers and medical schemes. One of the key recommendations from the committee was the need for the development of appropriate coding standards for South Africa. In addition to this recommendation, the results of a survey conducted by the Council to determine the type of information medical schemes were collecting and the quality thereof, revealed serious gaps and poor standardisation.

At the beginning of 2004, the Council for Medical Schemes, the Department of Health and industry stakeholders formed a task team whose primary purpose was to develop recommendations for an

[1] International Statistical Classification of Diseases and Health-related problems – Tenth Revision

appropriate strategic plan for the successful implementation of the ICD-10 in the public and private health sector.

This document outlines the progress made to date and the recommendations made by the task team and its subcommittees with regards to operational, technical, training and confidentiality issues pertaining to the implementation of ICD-10.

1.1. Rationale of the implementation of ICD-10

The rationale behind the implementation of ICD-10 is fourfold. Firstly, there was a need to standardise data collection processes in the industry. Secondly, regulation 5(f) of the Medical Schemes Act 131 of 1998 prescribes the manner of submission of claims by health services. Thirdly, there was a need to facilitate an efficient reimbursement system, for providers that was consistent with legislation and improves risk management practices by medical schemes. And lastly, the introduction of the Medical Schemes Act in 1999 saw the emergence of a minimum set of guaranteed benefits to be covered by medical schemes. Entitlement to these benefits is diagnosis-driven and is appropriately identified using ICD-10.

1.2. National ICD-10 implementation task team

In 2004, a National Task Team on ICD-10 Implementation was formed. The task team was led by the Council for Medical Schemes and the Department of Health and included wide representation from industry stakeholders. The purpose of the task team was to develop an implementation plan for ICD-10 in the private sector. The task team would also oversee the implementation of ICD-10.

The task team met on a monthly basis in order to finalise the implementation plan and once the plan was implemented, the focus shifted to monitoring the implementation. All stakeholders are encouraged to provide inputs to the task team on all matters pertaining to the implementation process.

1.3. Key focus areas of the task team

The Task Team is the main decision-making body whose primary purpose is:

- To develop an implementation plan
- To provide oversight, responsibility and monitoring capacity
- To conduct an assessment of industry readiness

In addition to the task team; four subcommittees were formed, namely:

a) Operational subcommittee:

The operational subcommittee is responsible for the following matters:

- Licensing issues
- Communication with stakeholders
- Privacy and Confidentiality
- Assessment of public and private sector readiness
- Role of switching companies

b) Technical subcommittee:

The technical subcommittee is responsible for the following matters:

- Coding level
- Adjudicate in disputes on codes
- Evaluate scope of practice of healthcare providers
- Investigate rules and applications
- Primary vs. secondary diagnosis

c) Training subcommittee

The training subcommittee is responsible for the following matters:

- Minimum training standards for ICD-10 coding
- Recommend training material and processes
- Recommend training institutions
- Recommend accreditation and qualifications for training

d) Confidentiality subcommittee

The confidentiality subcommittee is responsible for the following matters:

- To develop a framework for informed consent from medical scheme members and
- Inter-provider referrals

1.4. ICD-10 Implementation Plan

The task team developed an implementation plan for ICD-10 which entailed a phasing-in period starting on 1 July 2005. The phasing in process entailed four periods that are described below:

Phase I: Implementation period – 1 July to 30 September 2005

The implementation of ICD-10 from July 1 2005 entailed mandatory submission of ICD-10 codes by all healthcare providers except pharmacists, clinical support and allied healthcare providers. The mandatory submission of ICD-10 codes by these groups was postponed until 1 January 2006. But, if the condition for which the service was rendered was a Prescribed Minimum Benefit or a requirement as part of a contractual agreement, ICD-10 coding was mandatory for all health providers (including pharmacists and clinical support and allied healthcare providers).
A "no code no pay" principle applied during this phase. During this initial phase, a code per line item was required. The expected code had to have a minimum of three digits and be alpha numeric, and had to appear as per the ICD-10 manuals or the BHF/DXS ICD-10 Master Industry Table. No clinical validation or validation of primary codes was effected during this phase for routine claims, outside of existing contractual arrangements and the Prescribed Minimum Benefits (PMB) list. An active monitoring system to monitor turn-around times for the reimbursement of healthcare providers was developed and implemented.

Phase 2: Implementation period – 1 October to 31 December 2005

All healthcare providers except pharmacists were required to provide a valid primary ICD-10 code in the primary field. In the event that a secondary code was required, the code was also validated during this phase. All codes were to be coded to the correct level of specificity (3rd, 4th or 5th level, as appropriate). Medical schemes were encouraged to accept a code for unspecified conditions submitted by healthcare providers, unless it is stipulated differently in their contractual arrangements or related to PMBs. There was to be no clinical validation of codes outside of existing contractual arrangements and PMBs.

Phase 3: Implementation period – 1 January to 30 June 2006 (extended until further notice)

All healthcare providers must submit claims with complete codes (3rd, 4th or 5th character codes, as appropriate). The validation process for primary and secondary codes continued during this phase. However, there was no clinical validation of codes outside existing contractual arrangements and PMBs.

Phase 4: Implementation period – Postponed in 2006 until further notice

This phase entails the initiation of clinical validation rules for primary and secondary codes by schemes.

2. REPORT OF THE OPERATIONAL SUBCOMMITTEE

2.1. Background

Participation includes coding experts, software providers, switching companies, Department of Health representatives, professional organisations, provider groups, hospital groups, medical schemes and administrators.

2.2. Terms of reference

The operations subcommittee is responsible for the following matters:

- ICD-10 Licensing issues
- Communication with stakeholders
- Privacy and Confidentiality
- Assessment of public and private sector readiness
- Role of Practice Management Software and switching companies

2.3. ICD-10 Licensing

It has since been established that there are two types of licenses for ICD-10 that currently exists in the country. The first type is a license owned by the public sector for sole use in the public sector. The second type of licence is that owned by individual companies. These licenses allow use or distribution of ICD-10 codes in the private sector, either in print or in electronic format. Each license from the WHO was subject to differing license terms. Since it is imperative that all license holders conform to standards set out by the WHO on the use of ICD-10, the Operations Subcommittee deemed it appropriate to approach the WHO for guidance regarding the adoption of ICD-10 nationally, and to ascertain whether any changes to current licensing would be necessary.

The Operations subcommittee collated all available information regarding the existing license holders and submitted this information to the WHO together with a letter outlining our concerns and queries, in June 2004.

The WHO responded as follows:

a. The existing licenses remain valid, and no new license would need to be granted in the short term to allow implementation of ICD-10. The organisation expressed satisfaction that South Africa has

adopted ICD-10 but made it absolutely clear that ICD-10 should be used as prescribed by WHO in order for local statistics to hold any value internationally.

b. Longer term, it is hoped that the continued interaction between the National Department of Health, the Council for Medical Schemes and the private sector with the WHO, would result in the granting of a single ICD-10 license for the country. To this end, the establishment of a national standards body would be seen as a first step towards the granting of a single national license for ICD-10.

c. It was further confirmed through discussions with WHO, that it is an express condition of all licenses that no fee may be charged for the distribution of ICD-10, except such fees as may be appropriate to cover distribution (print or electronic formats) or installation and integration costs for software packages.

d. More importantly, since ICD-10 exists in the public domain, it was stated that no profit may be earned through any value-added packages or products, for the use of ICD-10 in such products.

e. The WHO also confirmed that healthcare providers do not require individual licenses in order for them to access the codes for facilitating claims submission.

The Board of Healthcare Funders (BHF) holds a license from the World Health Organisation which allows distribution of an electronic version of the ICD-10 codes, to all stakeholders. Some of the requirements for the licence are that BHF keep a register of all the users of ICD-10 codes and software providers have assisted with this task too. The development and maintenance of the electronic ICD-10 list (the BHF-DXS ICD-10 Master Industry Table) has been one of the main tasks of the Operational subcommittee. This is the only official electronic version for use in the South African healthcare industry.

Standardisation of ICD-10 in the form of an electronic list has ensured that software developers, switching companies and other stakeholders have access to ICD-10 lists. This has had the effect that all stakeholders have access to the standard ICD-10 list for South Africa.

2.4. Communication with stakeholders

One of the most important tasks of the Operations subcommittee is to communicate all decisions made by the National Implementation Task Team. This is not without its challenges, since the audience is broad and very varied. Regular Task Team meetings have been, and continue to be, held monthly. The meetings are open to all stakeholders, and attendance is always good.

In addition, the Operational subcommittee has compiled and published regular circulars on the CMS website. These are official documents outlining the various rules and guidelines relating to the use of ICD-10 in general, and the application of ICD-10 coding in South Africa, as well as reports on the status of the ICD-10 implementation project.

Official communications are listed below, and are available on www.medicalschemes.com :

CMS Circular Number	Title	Date of publication
46/2004	Implementation of ICD-10 coding	1 October 2004
58/2004	ICD-10 coding process	17 December 2004
23/2005	Final ICD-10 implementation plan	14 June 2005
25/2005	ICD-10 coding requirements for clinical support and allied health professionals	28 June 2005
32/2005	Update on the implementation of ICD-10 coding: all you need to know	25 July 2005
35/2005	ICD-10 inclusion on claims – Guidelines on usage	18 August 2005
36/2005	National Task team on implementation of ICD-10 published guidelines on ICD-10 submission – Guidelines are attached to this Circular	18 August 2005
52/2005	ICD-10 codes for Multi-drug resistant TB	29 September 2005
53/2005	Extension for submission of ICD-10 codes by blood transfusion services	29 September 2005
10/2005 (PMB data)	ICD-10 compliance statistics: communication to providers	3 November 2005
64/2005	National Task team on implementation of ICD-10: collection of high level data from medical schemes	7 November 2005
12/2005 (PMB data)	Most recent circular with ICD-10 coding for PMB conditions	8 December 2005
21/2006	Postponement of Phase 4 of ICD-10 implementation: clinical validation	4 May 2006
23/2006	Development and use of Quick Reference Code (QRC) lists for ICD-10	10 May 2006
33/2006	Validity of unspecified, other specified, sign & symptom and default ICD-10 codes	25 July 2006
42/2006	ICD-10 Version 2 (2005) products and updating of the BHF/DXS ICD-10 master industry table	28 September 2006
43/2006	ICD-10 coding of mixtures on medicine claims	28 September 2006

Details of the content of each of these circulars are provided in the reports of the Technical Subcommittee of the National Task Team, as well as the Training Subcommittee where appropriate.

2.5. Confidentiality

Confidentiality is used as a generic term that includes privacy, confidentiality and security of patient information. The issue of confidentiality straddles a variety of legislative provisions. There are also operational implications regarding the transmission of patient information from one point to the next. As a result, the task team agreed to the formation of a committee that will focus solely on the development of a framework for the maintenance of patient confidentiality. In March 2006, a subcommittee on confidentiality of patient information was formed.

2.6. Assessment of public and private sector readiness

The phase-in process was developed to minimise the impact of operational and change management issues on the implementation of ICD-10. It also became necessary to form a contingency team that would deal with urgent operational and other issues impacting on the implementation process. Initially, the team met on a weekly basis, however once the process stabilised, it met monthly.

2.7. Role of software and switching companies

One of the important stakeholders in the implementation of ICD-10 has been software houses and switching companies who manage and process patient information from providers to medical schemes on a daily basis. The participation of these entities helped in the development of appropriate electronic standards for the transmission of ICD-10 codes.

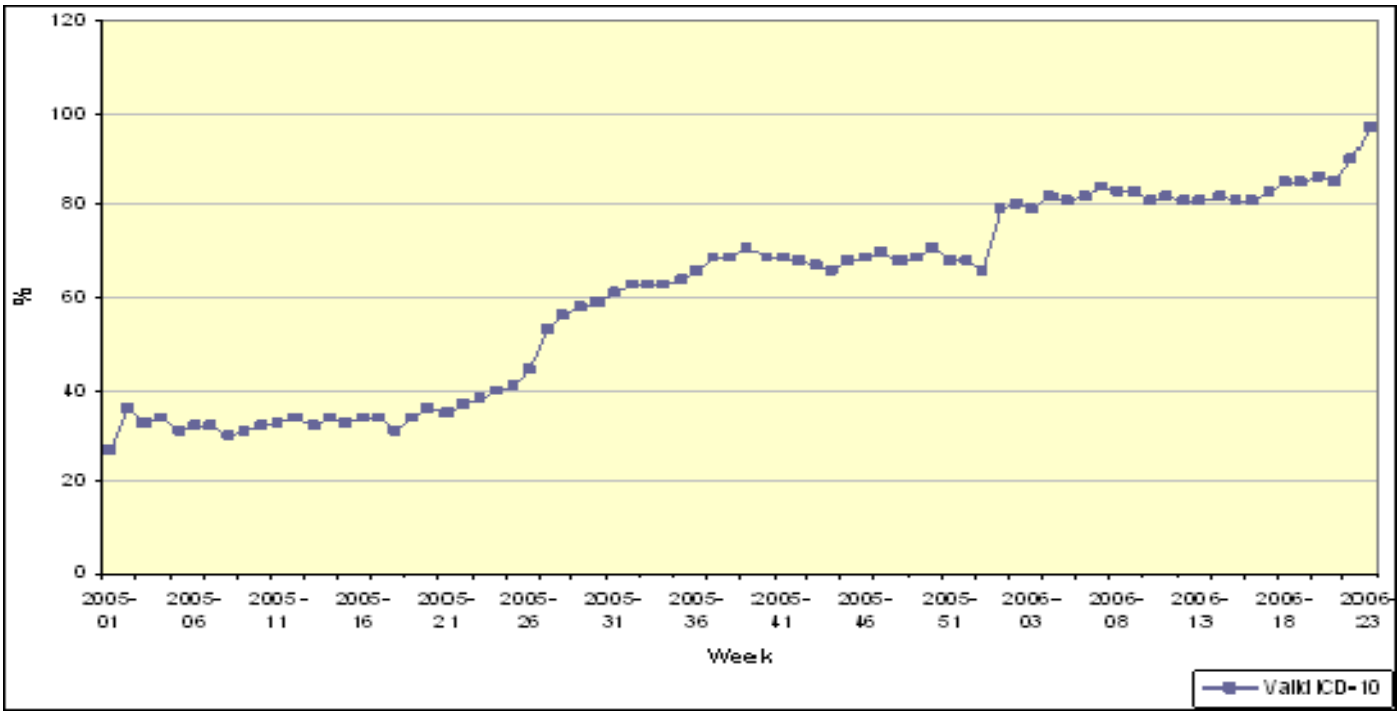
2.8. Standards Advisory Body

The Department of Health, through NHISSA, is in the process of setting up a standards body to be called the National Health Standards Advisory Body. Once established, this body should be able to take over the functions of the implementation task team and subsequently all the responsibilities of the standards body.

Over time, this body will be responsible for the continued maintenance and updating of ICD-10 codes, liaison with the WHO on coding related matters and the continued developments of adequate standards for privacy, confidentiality and security.

2.9. ICD-10 Compliance Statistics

The graph below shows a trend analysis of all the ICD-10 compliance data from several medical schemes from the 1 July 2005, when ICD-10 was implemented, till May 2006.



Graph courtesy of BHF

3. REPORT OF THE TECHNICAL SUBCOMMITTEE

3.1. Terms of reference for the ICD-10 Technical Subcommittee

- To standardise coding practices of ICD-10
- To develop consensus on the specificity of ICD-10
- To develop criteria for submission of ICD-10 by diagnosing practices

3.2. Purpose of this Subcommittee

To compile a document containing standardised ICD-10 coding principles for South Africa. The compilation of a 'Standards Document' for all technical decisions taken is essential to ensure uniform coding in South Africa.

3.3. Placement of ICD-10 codes on claims

The task team resolved that it was beyond its mandate to make a determination on who are the diagnosing providers and who are not. This was considered to be the domain of professional regulatory bodies. The Task Team's role is to assist in encouraging appropriate ICD-10 coding and to entrench it into the current common practice.

It was agreed that ICD-10 code(s) must be provided by the attending healthcare provider. This includes healthcare providers rendering supporting services such as radiology and pathology. The code is placed on each line item of service rendered on an account or claim. The referring healthcare provider's ICD-10 code(s) are reflected at a header level. The practice of flooding codes from the header to line level is discouraged as it has been found to be problematic for the following reasons:

1) Possible differences in dates of service;
2) Different dependants being treated at the same time;
3) Inability to identify Prescribed Minimum Benefits (PMBs).

All healthcare providers must familiarise themselves with their software programs regarding inputting and/or selection of ICD-10 codes. It remains the responsibility of the software vendor to ensure that the claim, whether printed on an account or compiled in an electronic file, is correct.

In the case of hospital claims, the ICD-10 code(s) is compulsory only at a header level. There is no need to provide codes at a line item level by hospitals. However, for all other healthcare providers, ICD-10 codes must be reflected at the line item level. Provision of ICD-10 codes at the header level of the claim

would only be required to reflect the referring doctor's code(s). This however, remains optional but does not preclude the healthcare provider from providing all other details that should be included at a header level.

The use of ICD-10 codes on modifier lines is currently not mandatory, except for modifier 0017. An ICD-10 code(s) is required to indicate the diagnosis when modifier 0017 is used. As a business rule, a modifier is regarded as being part of the preceding code and is never used alone. As a result, the ICD-10 code for the modifier will be assumed to be the same as that for the main code. In the case of modifier 0017 this code is used as a stand-alone and does not have to be preceded by another code.

Dental laboratories do not submit their accounts directly to medical schemes, but through the dentist for whom the dental laboratory work was done. In this instance, only item 8099 appears on the account(s) of the dentists to reflect the laboratory work, and not the T-codes. ICD-10 code(s) should be added to item 8099 only. Should medical schemes use the T-code entries from the dental laboratories to make payment for the dental laboratory work, the medical scheme can populate the ICD-10 code information to each of the T-code lines.

3.4. Prescribed Minimum Benefits (PMBs)

All members of medical schemes are guaranteed a minimum set of benefits called prescribed minimum benefits. The benefits now include a limited set of chronic conditions and emergency medical conditions. All of these benefits are identifiable through a diagnosis. Therefore, access to these benefits can only be effected through the disclosure of a diagnosis. Currently, all PMBs are coded, thus making it easy to identify them using ICD-10 codes (refer to the website of the Council for Medical Schemes www.medicalschemes.com for the latest information). For purposes of appropriate identification of PMBs, all claims for PMB conditions require the appropriate ICD-10 codes to their full specificity. Coding of all diagnoses is important as the 'No ICD-10 code(s) no pay' rule applies for services rendered for PMB conditions from 1 July 2005.

3.5. Specific rules in terms of ICD-10 coding

- If a provider makes a diagnosis, he/she will need to supply ICD-10 code(s), even on pre-paid accounts in order to allow the medical scheme member to submit claims, that are compliant with legislation, to the scheme.
- Only the ICD-10 code(s) should be reflected on the member's account and not the description of the ICD-10 code

- The requirement to submit ICD-10 codes also applies to all claims submitted by the medical scheme member to a medical scheme even if the account has been paid in full, as this will facilitate a member's refund by the medical scheme.
- A patient or member (3rd party) may not code an account or prescription themselves; the coding has to be done by the healthcare provider or practice rendering the service. As with all other codes, it is the healthcare provider's responsibility to provide this information in an accurate and reliable manner.
- As per ICD-10 conventions, a provider should not code suspected/query/excluded conditions until they have been confirmed – signs and symptoms must be used as interim codes which can then be updated once confirmatory results are received.
- No healthcare provider should be compromised if their codes differ from that of other healthcare providers treating the same patient at the same time.
- No accounts with ICD-10 code(s) may be rejected due to clinical interpretation of coding during the first phases of implementation, unless there are existing contractual arrangements, or coding is submitted for a Prescribed Minimum Benefit (PMB) condition. (Please note that Phase 4: Clinical validation was postponed until further notice). The fact that valid ICD-10 codes are supplied on line level will be sufficient.
- In circulars previously sent out by the Council for Medical Schemes it was not clearly stipulated that ALL codes submitted had to be valid codes (if multiple codes are submitted) for Phase 2 of the implementation process on 1 October 2005. There has been a misinterpretation by some role players that only one valid code is required, i.e. only the primary ICD-10 code must be valid. It is important to note that ALL codes submitted should be valid and complete as per the WHO rules and conventions.
- The use of multiple codes for one visit may be appropriate and the codes are to tie in with the rules for selection of a primary ICD-10 code and sequencing of secondary codes. The fact that two different diseases may be classified under the same code is a training issue for clarification of the ICD-10 structure and classification style.
- The use of ICD-10 Volume 1 (Tabular list) in isolation will lead to basic rules of assignment being missed. Volume 3 (Alphabetic Index) should be used to find the lead ICD-10 code(s) and Volume 1 to verify that the ICD-10 code selected is the correct code for the specific diagnosis.
- Diagnostic Related Group (DRG) groupers should not be taken into consideration when applying coding rules and conventions and that these groupers would need to be adapted to ICD-10 rules and not vice-versa.
- **Not all codes need to be coded to a 5th character!! This is also true for 4th character codes, since some ICD-10 codes are valid to three characters only. In all circumstances a diagnosis should be coded to the full specificity of that specific ICD-10 code.**

- ICD-10 codes must be supplied on each line item of a claim. This includes line items such as consultations, procedures, services rendered, and medicine and material codes.
- The foundation from which to work in terms of ICD-10 coding is the electronic BHF/DXS ICD-10 Master Industry Table obtainable from the Board of Healthcare Funders. This electronic product is regarded as the industry standard for ICD-10 codes and contains all the ICD-10 codes used in the industry.

3.6. Different ICD-10 codes on different claims

Health professionals will not be penalised by medical schemes if their ICD-10 codes differ from that of other providers treating the same patient at the same time. The issue of determining who should decide on the main diagnosis of a patient is beyond the mandate of the Task Team. The Task Team's role is to assist in slotting in ICD-10 into current common practice, not to interfere with prevailing clinical processes.

3.7. Pre-authorisation versus claim use of ICD-10 codes

A standard response was drafted to explain the use of ICD-10 codes for pre-authorisation versus claim(s) submission: "Medical Scheme Regulation 5(f) outlines legislative requirements regarding the manner of submission of a claim. The legislation assumes a discharge diagnosis to be the diagnosis that eventually should be submitted to the medical scheme for reimbursement. It does not however, prescribe the requirements for pre-authorisation. Each medical scheme/administrator should ensure that their internal processes accept ICD-10 codes when submitted by healthcare providers for the purpose of pre-authorisation or use the verbal description given by the member/healthcare provider for translation into a pre-authorisation/admission code. The admission code must be updated by the healthcare provider(s) as the patient's condition progresses or when discharge takes place."

3.8. Some reasons for rejection of claims

A review of claims submitted since the mandatory submission of ICD-10 was begun on 1 July 2005, revealed that one of the reasons for rejection of claims by medical schemes was incorrect coding practices due to coding format errors. This however, could be eliminated by ensuring that care is taken when typing in ICD-10 codes on the accounts, as invalid formatting could lead to rejections.

When manual typing of codes and ICD-10 file maintenance occur, healthcare providers, software vendors and other relevant stakeholders should take note of the following common errors:

Error 1: Three character codes

Example: Code A09

The correct submission is: A09

Common typing/transcription errors:

A09. (Dot incorrect)

A09☐ (Space incorrect) ☐ = space

A09.☐ (Space and dot incorrect) ☐ = space

Why does this matter?

When a code is carried to the medical scheme or administrator via an electronic switch, various characters are used in this message to i.e. distinguish and separate data fields. In the above example, the dot (.) in an ICD-10 code means that a character should follow it. When electronically validating a claim, the system will encounter a problem because it expects another character and in this case there is no character or a space.

Error 2: Multiple three character codes

Example: Codes G64, G92 and G98 all apply to the same patient encounter

The correct submission is: G64/G92/G98

Common typing error:

G64.☐/G92.☐/G98. (Dots and spaces follow each code - this is incorrect) ☐ = space

When an electronic claim is created and submitted, the software program should automatically send the above example as G64/G92/G98.

Electronic switching or transacting simply transforms what was typed into a field into the correct message format. This message is then received by the medical scheme or administrator. The human interaction with the software system must be correct at the input stage, to ensure that correct information is received at the other end of the information chain.

Providers have to familiarise themselves with the exact way in which the software program requires the operator (e.g. the accounting staff in the practice) to type and/or select ICD-10 codes. It is the responsibility of the practices' software vendors to ensure that the claim, whether it is printed on an account or compiled in an electronic file, is correct.

Error 3: Extended codes to maximum specificity

For providers to submit valid ICD-10 codes, coded to the maximum specificity (i.e. 3, 4 or 5 character codes) which was the requirement for Phase 2 of the ICD-10 implementation process from October 1, 2005, the dot (.) must be submitted as part of the code.

Error 4: Multiple extended codes

The correct submission of multiple codes is: M67.2/I15.0/K52.9

Each code should be typed into a separate field in the practice management software, as follows:

M67.2

I15.0

K52.9

Common errors:

M67.☐2☐/I15.0☐/☐K52.9☐ (Incorrect - no spaces allowed) ☐ = space

M67-2/I15-0/K52-9 (Incorrect - no hyphens allowed)

(M67.2)(I15.0)(K52.9) (Incorrect - no brackets allowed)

If the codes have been typed into separate fields as shown above, the software and the switch will ensure correct submission of the codes to the medical scheme or administrator.

Error 5: Using only the correct characters

No spaces are allowed to follow the code.

JO1.1 (Use of upper case O instead of a zero (0) is incorrect)

The correct submission is: J01.1

J01.l (Use of lower case "L" or upper case "I" instead of a one (1) is incorrect)

The correct submission is: J01.1

ICD-10 codes all follow the same format:

Three-character code: An alphabet (letter) followed by two numbers (LNN).

Four-character code: An alphabet followed by two numbers, a dot (.) and another number (LNN.N).

Five-character code: An alphabet followed by two numbers, a dot (.) and two numbers (LNN.NN).

However, for ICD-10 codes M45, T08, T10, T12, V98 and V99 where an 'X' is used as a place holder to add the fifth character at the correct position in the coding hierarchy, the format is as follows: An alphabet followed by two numbers, a dot (.) and an 'X; followed by a number (LNN.XN).

Morphology codes: An alphabet followed by four numbers, a forward slash (/) and another number (LNNNN/N)

Error 6: Inclusion of ICD-10 descriptions on claims

DIAGNOSIS DESCRIPTIONS SHOULD NOT BE INCLUDED ON PAPER OR ELECTRONIC CLAIMS. The reason for this rule is to maintain the patient's privacy and confidentiality.

General information regarding rejection of claims

All software vendors and switching companies must make provision for ICD-10 codes up to ten characters each and up to 10 complete codes per line.

Refer to Council for Medical Schemes (CMS) Circulars 35 and 36 of 2005 both dated 16 August 2005 for more detailed technical errors and requirements. It should be noted that the paper claim requirements are different from that of electronic claims and are currently being addressed through the Standard Claim Form subcommittee of the Private Healthcare Industry Standards Committee (PHISC). Notwithstanding the different requirements, ICD-10 codes must be reflected on every line item; dittos (“) or brackets may not be used on paper claims to show that the same code applies to several line items.

3.9. Guidelines and rules for Practice Management Application (PMA) software

Practice Management Application (PMA) software is expected to comply with the following guidelines and rules:

- Functionality of capturing ICD-10 codes, which is the domain of the PMA, must be provided.
- The standard electronic BHF/DXS ICD-10 Master Industry Table must be used.
- Facility to code up to the highest level of specificity, 3rd, 4th and 5th characters, as appropriate.
- The user must be able to alter previously selected ICD-10 codes, when required.
- Dagger/asterisk symbols must be displayed within lookup lists.
- Look-up lists are preferred over the manual typing of ICD-10 codes.
- Allow a maximum of ten ICD-10 codes per item.
- Allow a maximum 10-character length per ICD-10 code.
- Placeholders may be upper or lower case x / X (for example M45.x9).
- 3-character ICD-10 codes: No dot (.), no spaces, no hyphens.
- 4- and 5-character ICD-10 codes: No spaces, no hyphens, include dot (.) after third character.
- Supply ICD-10 codes on item level.
- Electronic claims: Delimited with forward slash (/) without spaces before and after the slash.
- Paper claims: Delimited with a space, a forward slash (/) and another space.
- Electronic and paper claims: Omit dagger/asterisk symbols.
- Paper and electronic claims: **NO** diagnostic descriptions should appear on claims.
- No ICD-10 codes for modifiers (except for modifier 0017) or dental laboratory items.
- Morphology codes must be catered for.

- Third parties (i.e. switching companies) must maintain the integrity of ICD-10 codes in its original format. Furthermore, the order of the ICD-10 codes may not be changed during transmission of data.

3.10. Implementation of ICD-10 in the South African healthcare industry

On June 14, 2005 the Council for Medical Schemes published Circular 25 of 2005 in terms of the final ICD-10 implementation plan in which it was stated that a less rigid approach would be followed with the implementation of ICD-10 in the South African healthcare industry in order for the process to be a success. The following four phases were followed:

3.10.1. Phase 1: Implementation period 1 July to 30 September 2005

- Mandatory submission of ICD-10 codes for diagnosing providers.
- During Phase 1, in instances where pharmacists, clinical support and allied healthcare providers do not make a diagnosis for a particular patient encounter, it was not mandatory to submit ICD-10 codes.
- Clinical support groups, allied healthcare providers and pharmacists were granted exemption from ICD-10 related rejections until 1 January 2006. However, this did not preclude these exempted providers from submitting ICD-10 codes on their claims before 1 January 2006, where they were able to do so.
- ICD-10 coding is mandatory for all healthcare professionals (including pharmacists, clinical support and allied healthcare providers) if the condition for which the service was rendered is being claimed as a Prescribed Minimum Benefit.
- ICD-10 coding is also mandatory if the healthcare provider is under specific contractual agreements with the medical scheme concerned, in which ICD-10 coding is one of the conditions of the agreement.
- A “no ICD-10 code(s) - no pay” principle applied, for diagnosing providers only.
- The relevant ICD-10 code(s) must be supplied on each line (item) of a claim, thus it would be acceptable if the information about a service containing the ICD-10 information were reflected on more than one line, for that specific service. All the information pertaining to a service does not have to be reflected on a single line entry, although it should be regarded as one entity.
- If not all ICD-10 codes can be accommodated on the same line as the procedure code, the ICD-10 codes can be strung along on the line below the main entry, not above, as per recommended standards.

- The order of the ICD-10 codes may not be changed during the transmission process.
- Hospital accounts require ICD-10 codes to be reflected on header (claim) level only.
- A sign/symptom code can be used appropriately for any situation in which no definitive diagnosis is made. The same applies to non-diagnosing providers who want to supply ICD-10 codes. Alternatively, these healthcare providers may use the referring provider's diagnostic code when this is available.
- The combination coding rules pertaining to the WHO rules for dagger and asterisk codes and sequelae codes was followed during the first phase.
- Validity checks during phase 1 comprised only:
  - The presence of a minimum 3 character ICD-10 code
  - The ICD-10 code(s) being alpha-numeric
  - The code(s) appearing in the ICD-10 coding manuals from the World Health Organisation or the BHF/DXS ICD-10 Master Industry Table supplied by the Board of Healthcare Funders (BHF)
- Clinical validation or validation of primary codes by medical schemes or administrations was not allowed during phase 1, unless there were existing contractual arrangements, or coding was submitted for a Prescribed Minimum Benefits (PMB) condition.
- Diagnosis coding is not limited to healthcare providers in private practice, therefore ICD-10 coding also applies to healthcare services rendered in the public sector.
- Summary of Phase 1: 1 July to 30 September 2005
- Claim where diagnosis is made and supplied – No ICD-10 code = No payment
- Any claim for a PMB condition – Valid ICD-10 code required
- Any claim under contractual arrangements – Valid ICD-10 code required
- Claim where no diagnosis is made – ICD-10 not mandatory
- In Phase 1 a VALID code is an ICD-10 code that must appear as per the specifications and rules contained in the ICD-10 set of books (World Health Organisation books) or the BHF/DXS ICD-10 Master Industry Table.

3.10.2. Phase 2: Implementation period 1 October to 31 December 2005

- No valid AND complete ICD-10 code - no pay, for diagnosing providers only.
- Mandatory submission of codes for diagnosing providers.
- ICD-10 coding is mandatory for all healthcare professionals if the condition for which the service was rendered is being claimed as a Prescribed Minimum Benefit.

- ICD-10 coding is also mandatory if the healthcare provider is under specific contractual agreements with the medical scheme concerned, in which ICD-10 coding is one of the conditions of the agreement.
- The primary code should be in the primary/first position followed where applicable, by secondary code(s).
- Should a combination coding rule be applicable, i.e. two codes to correctly describe the disease or condition (for example, with fractures, an external cause code is required, etc), the secondary code(s) must also be supplied.
- The ICD-10 codes must be supplied on each line item of a claim.
- All codes should be coded to the correct level of specificity, 3rd, 4th and 5th level. In some cases the 3-character code is the correct level of specificity (e.g. I10)
- ICD-10 codes for 'unspecified' conditions (those codes which contain .8 or .9 as a fourth character) are valid and allowable and should be recognised by medical schemes.
- In any situation in which a definitive diagnosis is not made, a sign/symptom code (noted as a code that begins with an "R" in the ICD-10 coding list) would be appropriate for use and considered valid in the primary position.
- No clinical validation by medical schemes or administrators will be allowed during phase 2, unless there are existing contractual arrangements, or coding is submitted for a PMB condition.
- In summary Phase 2: 1 October – 31 December 2005:
  - Claim where diagnosis is made and supplied – Valid AND complete ICD-10 code(s) required
  - Any claim for a PMB condition – Valid AND complete ICD-10 code(s) required
  - Any claim under contractual arrangements – Valid AND complete ICD-10 code(s) required
  - Claim when no diagnosis is made – ICD-10 code not mandatory
- In Phase 2 and subsequent phases – a VALID code is an ICD-10 code that must appear as per the specifications and rules contained in the ICD-10 set of books (World Health Organisation books) or industry standard table. The code should also be at its appropriate 3rd, 4th or 5th character level (a COMPLETE code), which is used in compliance with the rules governing its application.

  Example 1: A VALID code is one that is a primary code placed in the first position on a claim line, i.e. the relevant code describing the main reason why the medical scheme beneficiary consulted the healthcare professional.

Example 2: If the reason a medical scheme beneficiary is seen is due to a complication of an underlying illness, the primary code is the relevant code for the underlying illness while secondary codes describe the particular complications that the medical scheme beneficiary presents with. In this case, the VALID primary code is for the underlying illness.

- Asterisk (*) codes and external cause codes (ECC) are valid ICD-10 codes, but they are not valid as primary diagnostic codes therefore should only be used in the secondary position. Combination coding rules for external cause of injury codes and poisoning codes applies.
- A COMPLETE ICD-10 code means any code coded to its highest level of specificity at its appropriate 3rd, 4th or 5th character level.

  Example: Code S72.3 (Fracture of shaft of femur) is not complete, as more detail of the diagnosis is required, namely, if it was an open or closed fracture. The COMPLETE code for an open fracture femur shaft is S72.31.

3.10.3. Phase 3: Implementation period 1 January to 30 June 2006

- ALL healthcare providers, including pharmacists, clinical support and allied healthcare providers, must submit claims with complete ICD-10 codes (3rd, 4th and 5th character codes) [in some cases the 3-character code is the correct level of specificity (e.g. I10)] on each line item of a claim (except for hospitals which are required to submit ICD-10 codes at a header level). The referring provider's ICD-10 code(s) must appear at header level, where applicable.
- The validation process for primary and secondary codes continues during this phase.
- No clinical validation by medical schemes or administrators is allowed during Phase 3, unless there are existing contractual arrangements, or ICD-10 coding is submitted for a PMB condition.

3.10.4. Phase 4: Implementation period 1 July 2006 onwards (postponed)

- Full implementation of ICD-10 codes with clinical validation of all codes supplied. All ICD-10 diagnosis coding will be performed as per the WHO's rules and conventions.

Important note about the implementation of Phase 4:
On March 15, 2006 at the ICD-10 Main Implementation Task Team meeting it was agreed to postpone the implementation of Phase 4 until further notice. Phase 3 therefore continues. Please refer to Circular 21 of 2006 (dated May 5, 2006) from the Council for Medical Schemes for more information about the postponement of Phase 4: Clinical validation.

3.11. Clinical validation

Clinical validation of diagnosis (ICD-10) and procedure (e.g. NHRPL/CCSA/CPT) matches is part of Phase 4 (postponed to July 2007) of the ICD-10 implementation strategy. In anticipation of Phase 4, some schemes are already issuing information messages to providers where "mismatches" between diagnosis and procedures are being perceived. No rejection of these ICD-10 codes may lead to a refusal to pay by medical schemes or administrators for the services rendered based on the "incorrect" ICD-10 code if the ICD-10 is a valid and complete code on the BHF/DXS ICD-10 Master Industry Table.

Clinical validations must take into consideration the ability for ICD-10 code sequences to change pending changes in a patient's condition and that sometimes, secondary codes (e.g. asterisks) should be used for matching conditions to procedures. Thus consistency to the industry standard must be maintained in this regard. Moreover, matching the diagnosis and treatment should not become prescriptive in nature. It will be up to each individual medical scheme to profile healthcare providers using treatment that differs from the norm.

The purpose of the clinical validation phase of the ICD-10 implementation is to monitor appropriateness of care by correlating diagnosis and procedure codes. However, at this stage, there is no industry standard in this regard, making such an initiative difficult. In addition the varying sequencing rules of ICD-10 make a direct match of a primary diagnosis to a primary procedure challenging. It was agreed that the specialist groups (disciplines) should be involved in mapping this validation work.

3.12. Clinical support and allied healthcare providers

The Technical subcommittee took cognisance of the fact that clinical support and allied healthcare providers may face particular challenges regarding submission of ICD-10 codes on a claim as a result of the following:

- The referring healthcare provider may not have supplied an ICD-10 code on referral documents.
- The clinical support or allied healthcare providers may not make an actual diagnosis when rendering a service to a medical scheme beneficiary.

In amended Circular 25 of 2005 (Council for Medical Schemes dated June 29, 2005) it was agreed to postpone the rejection of claims from clinical support and allied healthcare providers until January 1, 2006. As a result, no claim was rejected on the basis that an ICD-10 code does not appear on that claim, unless a diagnosis has been made by the healthcare provider concerned.

Exceptions to this ruling:

- Clinical support and allied healthcare providers are always required to provide ICD-10 codes if a diagnosis is made.
- In order to claim a benefit as a Prescribed Minimum Benefit, valid ICD-10 codes must be supplied.
- All providers who are under specific contractual arrangements where ICD-10 coding is included as a condition of such contracts must continue to supply valid and complete ICD-10 codes.

Exempted clinical support and allied healthcare providers included: anaesthetists, pathologists, radiologists, and nuclear medicine specialists.

Other healthcare providers exempted until January 1, 2006 included: ambulance services, ambulance emergency services, emergency services, blood transfusion services, blood and blood product couriers, clinical technologists, medical technologists, biokineticists, dental technician laboratory, hearing aid acousticians, medical scientists, psychometrists, radiographers, and social workers.

As of January 1, 2006, the inclusion of diagnosis codes on claims submitted to schemes or claims given to members for submission to schemes, applies to both the diagnosing and non-diagnosing providers.The clinical support groups, of which radiologists and pathologists are a part, should include the referring provider's ICD-10 code(s) as an optional code (ideally this should be compulsory), and include their own code(s) where appropriate, even if it differs from that of the referring provider. Clinical support and allied healthcare providers' codes must be submitted on each line item of the claim.

3.13. South African ICD-10 Coding Standards

The ICD-10 Technical Subcommittee put together a South African ICD-10 Coding Standards document to assist the South African healthcare industry with correct coding for ICD-10. This document was compiled from coding decisions made by the Technical Subcommittee and is constantly updated as required. This document should also be used for training purposes to ensure that coding in South Africa is standardised. Refer to the South African ICD-10 Coding Standards document for a complete set of the technical standards set by the Subcommittee. It is important to check the website of the Council for Medical Schemes (www.medicalschemes.com) regularly to ensure that the latest version of the document is used in the healthcare industry.

3.14. Standard electronic BHF/DXS ICD-10 Master Industry Table

The standard electronic BHF/DXS ICD-10 master table (ICD-10 master table), available from the BHF, must be used as the basis of all ICD-10 coding in South Africa. This table was specifically created to ensure that:

- all role players have easy access to a locally applicable set of codes,
- the integrity of the ICD-10 system can be maintained and that maintenance of the system should be done at a central point, and
- the list can simply and easily be incorporated into any software or paper-based system for coding of claims for submission, as well as for adjudication of those claims from a medical scheme's perspective.

The aim of this product (BHF/DXS ICD-10 Master Industry Table) is for everyone in the industry to use the same standard list/table of ICD-10 codes at the lowest possible cost.

BHF is handling the distribution and administration of the BHF/DXS ICD-10 Master Industry Table and will need to keep a log of all users in the form of a registration form that must be completed by each user of the table when it is purchased.

3.14.1. Updating of the standard electronic BHF/DXS ICD-10 Master Industry Table

The BHF/DXS ICD-10 Master Industry Table will be updated when necessary, on 1 March each year. The current set of ICD-10 codes will be maintained until February 28, 2007. It has been agreed that no changes will take place to the BHF/DXS ICD-10 Master Industry Table during 2006 to allow for a settling in period during the implementation process. Implementing this decision became difficult when Version 2 of the ICD-10 products became available from the WHO in 2005 and Version 1 ICD-10 products were no longer available from the WHO.

New ICD-10 books (Version 2 of ICD-10, 2005) do not need to be purchased by those who are using old books (Version 1 of ICD-10). An errata-type list of all changes needs to be included when the new books are purchased in order to alert users that new codes will not be recognised in the current industry table until the BHF/DXS ICD-10 Master Industry Table has been updated.

3.14.2. ICD-10 Manual: Version 2, 2005

The changes identified in Version 2, compared to Version 1, were not significant enough to warrant an entire BHF/DXS ICD-10 Master Industry Table update for 2006. Circular 42 of 2006, published by the Council for Medical Schemes, has a list of the most important differences

between the two versions. This list was compiled to assist users of Version 2 with identifying and using the correct codes from the BHF/DXS ICD-10 Master Industry Table until the end of February 2007. Effective to and from dates will be indicated on the BHF/DXS ICD-10 Master Industry Table and all code changes will be taken into consideration in the future for version control.

3.14.3. Validity of codes on the BHF/DXS ICD-10 Master Industry Table

On the BHF/DXS ICD-10 Master Industry Table, the column titled "Valid_ICD10_ClinicalUse" indicates which codes are appropriate for use in respect of being specified to the maximum level of specificity. In other words, those codes flagged as "N" are not at their maximum level of specificity e.g. some codes are invalid at a 3 or 4 character level and only valid at a 5-character level. Those codes flagged as "Y" are at their maximum level of specificity e.g. most codes in the musculoskeletal system starting with an "M" have 5 characters, indicating specific additional information about the site of involvement of that condition.

The column entitled "Valid_ICD10_Primary" is also important in terms of correct coding practice, and to prevent rejection of healthcare provider claims by medical schemes, because it identifies which codes are appropriate for use as primary or principal diagnosis codes, e.g. Morphology codes, asterisks codes and External Cause codes (V, W, X and Y codes) are flagged as "N" as they are never valid for use as a main/primary diagnosis and need to follow the principles of combination coding as stipulated by the WHO conventions for ICD-10.

3.14.4. Inclusion of other diagnosis-related classifications

The viability of adding “plug-ins” to the ICD-10 schema, such as DSM-IV, ICD-O, ICD-DA, etc was discussed. Most of the plug-ins consists of the basic ICD-10 codes with extra characters (5^{th} or 6^{th}) for extra specificity. The addition of extra characters into the BHF/DXS ICD-10 Master Industry Table needs to be investigated. The standard electronic claim form has an identifier for different code sets and it was agreed that code fields should allow for ICD-10 codes up to 10 characters in length. National standards will have to change from 5-character codes as the maximum level of specificity if plug-ins are introduced. This however, is an issue that would require proper consultation before a final decision can be taken.

3.14.5. Links or guidelines for multiple condition coding

The BHF/DXS ICD-10 Master Industry Table does not contain links or guidelines for multiple condition coding. Such enhancements would be considered part of a value add in third party encoder software products, which require special licenses from the WHO.

3.14.6. Other ICD-10 electronic products in the market

There are currently a variety of electronic ICD-10 products in the market besides the standard BHF/DXS ICD-10 Master Industry Table. However, these products should be aligned with the only official version of electronic ICD-10in South Africa, namely the electronic BHF/DXS ICD-10 Master Industry Table distributed by the Board of Healthcare Funders (BHF) to ensure standardisation of coding processes in the country.

3.14.7. Dagger codes not flagged to asterisk codes on the BHF/DXS ICD-10 Master Industry Table

Not all possible dagger codes are flagged to asterisk codes or with their asterisk combinations in the BHF/DXS ICD-10 Master Industry Table, as these need to be applied as is deemed clinically appropriate for individual cases. Thus knowledge of the conventions of the volumes of ICD-10, as well as clinical knowledge is critical in appropriate allocation of dagger and asterisk combinations.

In the BHF/DXS ICD-10 Master Industry Table, only codes as per the ICD-10 volume 1 were flagged as dagger codes, however, it does not necessarily mean that a non-flagged code cannot be used as a dagger code as per coding rules.

3.15. Coding Definitions

3.15.1. Primary Diagnosis (PDX) - Morbidity

The primary diagnosis or main condition is defined as follows:
It is the condition diagnosed at the end of the episode of healthcare, primarily responsible for the patient's need for treatment or investigation. It is the "main condition treated".

If there is more than one main condition, then the condition held most responsible for the greatest use of resources should be selected.

Only in circumstances where there is more than one "main condition" and no information is available to determine which of the conditions is responsible for the greatest use of resources should the coder revert to the default rule that allows selection of the first condition that the responsible clinician has recorded.

If no diagnosis was made, the main symptom, abnormal finding or problem should be selected as the main condition.

Episodes of health care or contact with health services are not restricted to the treatment or investigation of current illness or injury. Episodes may also occur when someone who may not currently be sick requires or receives limited care or services; the details of the relevant circumstances should be recorded as the “main condition”.

3.15.2. Primary code

The primary code is the code that describes the primary diagnosis, and must appear in the primary (first) position on a claim. Many patient encounters involve complications or sequelae of primary conditions, however a primary underlying condition exists, and this is the condition that defines the primary code.

3.15.3. Secondary Diagnosis (SDX)

This is an additional condition that affects patient care or may coexist with the main condition and may require:

- Clinical evaluation; or
- Therapeutic treatment; or
- Diagnostic procedures; or
- Extended length of hospital stay; or
- Increased nursing care and/or monitoring
- Increased intensity of nursing care

External cause codes also fall under secondary diagnoses.

3.15.4. Secondary code

Secondary codes are codes that further describe the patient’s condition or the cause of the patient encounter. Examples include diabetic retinopathy, motor vehicle accident (MVA), etc. The rules and conventions of ICD-10 coding as set out by the World Health Organisation (WHO) are applied to assign these codes appropriately.

3.15.5. Valid code

A valid code is an ICD-10 code that appears in the ICD-10 coding manuals according to the WHO rules and conventions and as specified in the BHF/DXS ICD-10 Master Industry Table. It comprises a primary code in the primary position on a claim. For multiple diagnoses, secondary codes are coded in the secondary position.

During Phase 1, of the implementation phase, this code had a minimum of 3 characters, while from Phase 2 onwards a valid code entails the relevant 3rd, 4th and 5th characters where these are specified in the references. Please note that the dot (.) in the ICD-10 codes preceding the 4th character is not regarded as a character, however it should be reflected in the ICD-10 code(s).

From 1 October 2005, the criteria for ICD-10 code(s) validity on claims are two-fold:

- **Valid**: Marked as such in the BHF/DXS ICD-10 Table, or as described in the ICD-10 manuals
- **Complete**: To the highest level of specificity as per ICD-10 rules

3.15.6. Co-morbid conditions

A pre-existing condition that may or may not increase resource usage and it may co-exist with the principal diagnosis. A co-morbid condition may become a primary diagnosis if it is the main condition being treated.

3.15.7. Complication

A complication usually arises subsequent to an existing condition, disease, pregnancy, injury, etc, or subsequent to treatment, procedures, and adverse reaction to drugs, chemicals, etc. A complication may become a primary diagnosis despite it not being the cause of admission.

3.15.8. Current Injury vs. Old Injury

A current injury is identified by the codes *(S00-T88) Injury, poisoning and certain other consequences of external causes*. An old injury is identified by the codes (*M00-M99) Diseases of the musculoskeletal system and connective tissue* or by the complication codes *(T82-T88)*

3.15.9. Sequelae (late effect)

Sequelae codes are used to indicate conditions that are no longer present but are the cause of a current problem now under treatment. Terms such as “old”, “no longer present”, “late effect”, or those present one year or more after onset of the casual condition may be used to indicate a sequelae condition. The note in the infectious disease chapter (see ICD-10 Volume 1, page 177), states that reference must also be made to Volume 2 guidelines for mortality and morbidity coding.

Diseases of the cerebrovascular system: Code I69 has same reference: i.e. the sequelae include conditions specified as such or as late effects, or those present one year or more after onset of the causal condition (see note in ICD-10 Volume 1, page 501).

ICD-10 Volume 2 on page 99 indicates that the disease causing the condition is no longer present. On page 104, it also states that the preferred code for the main condition is the code for the nature of the current condition, with the "Sequelae of" to be added as the additional code.

For sequelae of external causes of morbidity and mortality (Y85-Y89), see notes of ICD-10 Volume 1 page 1120.

Coding of sequelae of diseases requires two codes:

- The residual condition or nature of the sequelae (current condition or reason for admission) is coded as the primary code.
- The cause of the sequelae, previous condition no longer present, is coded as the secondary code.

3.15.10. Definitions of 'accidental', 'intentional', 'self harm' and 'undetermined intent'

- The meaning of 'accidental', 'intentional' and 'self harm' is self explanatory.
- The interpretation of 'undetermined' may have legal implications in mortality coding when the patient has died and a legal investigation is underway, based on a post-mortem.
- If the patient is still alive, then 'undetermined' will be deemed to mean 'do not know' the circumstances under which the poisoning, etc. took place.

3.15.11. Definition of 'uncertain' and 'unknown' when coding from the neoplasm table

- 'Uncertain' means that cell changes have been observed but details are unknown.
- 'Unknown' means that it is not known if any cell changes are present.

3.15.12. Definition of 'atypia'

'Atypia' is described as a "deviation from the normal or typical state".

3.15.13. Definition of neonate

The neonatal period commences at birth and ends at 28 completed days after birth.

3.15.14. Difference between 'routine' examination and 'screening'

- 'Routine' is when nothing is suspected or the usual.
- 'Screening' is when there is a suspected abnormality or when looking for something.

3.15.15. Definitions of 'poisoning' (T36-T50) and 'adverse effect'

Poisoning:

- Wrong dosage given or taken.
- Wrong medication given or taken.
- Medication given or taken by wrong person.
- Intoxication (other than cumulative effect).
- Overdose.
- Correct medicine taken with alcohol or non-prescription drug(s).

Adverse effect:

- Allergic reaction.
- Cumulative effect of drug taken or given correctly (toxicity).
- Hypersensitivity to drug.
- Idiosyncratic reaction.
- Paradoxical or synergistic reaction.

3.16. Consensus on specificity of ICD-10

ICD-10 codes will be used to the highest level of specificity in South Africa. The specificity of codes is critical for assessment of appropriateness of care, resource allocation, epidemiology of diseases and healthcare reform. It is important that coding of diagnoses should be conducted in the most accurate manner for all conditions.

The collection of certain specific 5th character diagnosis information such as External Cause Codes (ECC) pose challenges, but are most valuable for resource allocation, risk management, business management, and where necessary, investigation of possible fraud. Dropping the 4th and 5th characters for ECC is therefore not permitted, and where specific information is not available, the ".99" unspecified characters should be used in the 4th and 5th character position.

Medical schemes are also using ECC to ensure correct payment, for protection of both the member and the provider. It was felt that “bad coding habits” should not be encouraged and that correct, appropriate coding should be stressed upfront. International practice is to use all these codes and that some even go to a 6 or 7 character level although this level of specificity is not required for South Africa at this stage.

This requirement for coding to the maximum level of specificity came into effect during Phase 2 of the implementation process on 1 October 2005.

3.17. Standardisation of coding practices of ICD-10

The following is important when using the ICD-10 structure to code specific diagnoses:

- Specific ICD-10 codes cannot be allocated uniquely for certain circumstances due to the multi-usability of ICD-10 codes across all disciplines.
- Different rules for code application by different providers are not allowed. By allowing different sets of rules and conventions the entire process is undermined and the consistency in application is compromised.

3.17.1. Specific coding requirements for symbols

3.17.1.1. Dagger and asterisk symbols:

For electronic and paper claims, processes that are currently in place for dagger (+) and asterisk (*) symbols should be left as they currently stand and the symbols should be used/accommodated wherever possible. Since not all computer programs support the symbol used to indicate the dagger codes (†), it is recommended that coders use either a plus sign (+) or an exclamation mark (!). However, when using an electronic look-up or reference list containing ICD-10 codes, the dagger and asterisk symbols MUST be used to ascertain the correct combination codes that are required. In the electronic environment the plus sign (+) is used to indicate dagger codes and has been accepted as the standard symbol to be used instead of the (†) and (!) symbols.

3.17.1.2. Decimal point and forward slash symbols:

The decimal point (.) for all fourth and fifth character codes, and the forward slash (/) for morphology for neoplasms, are being retained and should always be reflected when codes with these symbols are used.

3.17.2. Digits versus characters

When referring to the ICD-10 code structure, the word ‘character’ is used as the standard terminology versus the word ‘digit’ i.e. codes will be referred to as 3, 4 or 5-character codes.

When looking at the structure of a code the dot (.) used before the 4th character is not counted as a character. For explanatory purposes: the 4th character actually contains two characters namely a dot (.) and a character (0-9).

3.17.3. 5th character mandatory versus optional use

Although the World Health Organisation (WHO) ICD-10 book (Volume 1) indicates that the use of a sub-classification, for example to indicate the site of involvement (5th character), is reflected for "optional" use, it was decided that all WHO rules and conventions were to be followed for South Africa and that the word "optional" be replaced with "mandatory".

Chapters where the 5th character is required are as follows:

CHAPTER	CONTENTS	USE OF 5TH CHARACTER
Chapter XIII	Diseases of the musculoskeletal system and connective tissue (M00-M99)	Subdivisions by anatomical site.
Chapter XIX	Injury, poisoning and certain other consequences of external causes (S00-T98)	Subdivisions to indicate open and closed fractures as well as intracranial, intra-thoracic and intra-abdominal injuries with or without open wound.
Chapter XX	External causes of morbidity and mortality (V01-Y98)	Subdivisions to indicate the type of activity being undertaken at the time of the event.
U codes unique to South Africa	Multi-drug resistant tuberculosis (MDR TB) (U50.-)	Type of drug for which the patient is resistant.

3.17.4. Using the 'X'/'x' as a 4th character in 5th character-level coding

The use of the 'X' as a 4th character place holder in 5th character level codes where no 4th character is available, e.g. M45, is an international standard and local software vendors agreed to abide by this. Use of either an upper case 'X' or lower case 'x' in the place of the 4th character in codes which do not have a valid 4th character, but must be specified to the 5th character for maximum specificity was investigated. Volume 2 does not specify this standard, but it is printed as an upper case 'X'; the current Private Healthcare Information Standards Committee (PHISC) standard however is that the 'x' is in the lower case. It was determined that the 'x'/'X' when used for this purpose must not be case sensitive.

Example:

M45 *Ankylosing spondylitis*

[Site code required which will be placed in the fifth character space]

M45.X9 *Ankylosing spondylitis, site unspecified*

Codes that require an 'X'/'x' in the fourth character position are:

M45.- *Ankylosing spondylitis*

T08.- *Fracture of spine, level unspecified*

T10.- *Fracture of upper limb, level unspecified*

T12.- *Fracture of lower limb, level unspecified*

V98.- *Other specified transport accidents*

V99.- *Unspecified transport accident*

3.17.5. Combination Codes

There are certain diseases or conditions that require two sets of codes to correctly or accurately describe a particular disease or condition. This is known as combination coding. The following are the four most common combination codes:

3.17.5.1. Sequelae codes

Late effects of a condition no longer present as a current illness. Initial condition must have occurred one or more years ago.

Example: Dysphagia due to stroke.

PDX: R13 *Dysphagia*

SDX: I69.4: *Sequelae of stroke, not specified as haemorrhage or infarction*

Note: The principal/primary diagnosis (PDX) is the late effect: dysphagia and the secondary diagnosis (SDX) is the initial or sequelae condition: due to stroke.

3.17.5.2. External cause codes to be used in addition to injury (S and T) codes

External cause codes permit the classification of environmental events, circumstances and conditions as the cause of injury, poisoning and other adverse effects. The South African standard is that all S and T codes are to be assigned together with the External Cause Codes, to their highest level of specificity. (Refer to chapter 19 of the ICD-10 books Volume 1.)

External cause codes are V, W, X, or Y codes

The PDX is the injury or poisoning code and the external cause code is the SDX.

Example: Open fracture neck of femur due to fall from tree, at home, whilst gardening.

PDX: S72.01: *Open fracture neck of femur*

SDX: W14.03: *Fall from tree, at home, whilst engaged in other types of work*

NOTE: The External Cause Code (ECC) section requires coding up to a 5th character level.

3.17.5.3. Dagger (+) and asterisk (*) codes

Codes marked with a dagger (+) are considered the primary code indicating the underlying disease.

Codes marked with an asterisk (*) are considered optional or secondary codes indicating the manifestation.

A dagger code (+) can be used on its own when there is no manifestation.
An asterisk code (*) can NEVER be used on its own or in primary position. There are 83 special asterisk categories listed at the start of the relevant chapters in volume 1 of the ICD-10 books.
Example: Tuberculous peritonitis

PDX: A18.3+: *Tuberculosis of intestines, peritoneum and mesenteric glands*

SDX: K67.3*: *Tuberculous peritonitis*

Note: The dagger (+) is the principal diagnosis (PDX) and the asterisk (*) is the secondary diagnosis (SDX).

3.17.5.4. Local infections

Coding of some infections require an additional code in order to identify the infecting organism(s).
Example: Acute cystitis due to E.coli infection

PDX: N30.0: *Acute cystitis*

SDX: B96.2: *Escherichia [E.coli] as cause of diseases classified to other chapters*

Note: The site of infection is coded as the primary diagnosis (PDX) and the infecting organism as the secondary diagnosis (SDX).

3.17.6. Clinically appropriate codes in the Musculoskeletal system and connective tissue section (M codes)

A concern regarding the clinical inappropriateness of certain 5th character choices for the M codes was raised. It was questioned whether there should be a South African standard for which 5th characters are appropriate for each M code. The conclusion was that all 5th characters should be

maintained/allowed for use as is the World Health Organisation (WHO) standard. Audits should be conducted to track the inappropriate use of 5th character options and this should then be taken up as a training issue. However, the BHF/DXS ICD-10 Master Industry Table, which was audited by the WHO and which is available to the industry via the BHF, only contains 5th character options within the M section that make clinically appropriate sense (e.g. M65.34 - *Trigger finger, Hand*) in order to maintain the clinical integrity of the codes used. When the BHF/DXS ICD-10 Master Industry Table is updated, all 5th character options within the M section even if the clinical integrity of the codes are not appropriate would be added, however, inappropriate 5th character codes will be marked as invalid.

3.17.7. Maternity codes that cannot be used as the primary diagnosis

The rules of ICD-10 pertaining to the maternity codes should be applied, namely, that codes from O80-O84 (delivery codes) should be used for primary morbidity coding only if no other condition classifiable to Chapter XV: *Pregnancy, childbirth and the puerperium* is recorded.

3.17.7.1. Maternity Z-codes that cannot be used in the primary position

The following Z codes may not be coded in the primary position as these must be used as additional information on the record of the mother who gave birth to indicate the birth outcome:

Z37.0 *Single live birth*
Z37.1 *Single stillbirth*
Z37.2 *Twins, both live born*
Z37.3 *Twins, one live born and one stillborn*
Z37.4 *Twins, both stillborn*
Z37.5 *Other multiple births, all live born*
Z37.6 *Other multiple births, some live born*
Z37.7 *Other multiple births, all stillborn*
Z37.9 *Outcome of delivery, unspecified*

3.17.8. "Sign and Symptom" codes (R00-R99)

R codes are valid in the following six situations:

(a) cases for which no more specific diagnosis can be made even after all the facts bearing on the case have been investigated;

(b) signs or symptoms existing at the time of initial encounter that proved to be transient and whose cases could not be determined;

(c) provisional diagnosis in a patient who failed to return for further investigation or care;

(d) cases referred elsewhere for investigation or treatment before the diagnosis was made;

(e) cases in which a more precise diagnosis was not available for any other reason;

(f) certain symptoms, for which supplementary information is provided, represent important problems in medical care in their own right.

Please note that the sign and symptom codes, R codes, must be used as a last resort.
It should also be noted that a 'diagnosis' may be a recording of a Sign and/or Symptom only, therefore the use of R codes are valid for use as primary diagnosis codes and should be recognised as such by medical scheme administrators.

3.17.9. Contact with health services for reason other than illness

When a patient visits a doctor for a full medical check-up, with no specific complaint, use the most appropriate code from the Z00-Z02 range of codes.

3.17.10. Coding for routine examinations:

3.17.10.1. Routine dental examination:

Routine examinations are often carried out by dentists in which no diagnosis is made and/or no treatment is rendered. The code recommended for use in such examinations is the following:

Z01.2 *Dental examination*

3.17.10.2. Routine examinations by radiologists:

Routine examinations are often carried out by radiologists, at the request of the referring healthcare provider. The code recommended for use in such examinations, for example, chest X-rays or a mammogram is the following:

Z01.6 *Radiological examination, not elsewhere classified*

3.17.10.3. Routine examinations by pathologists:

Routine examinations are often carried out by pathologists, at the request of the referring healthcare provider. The code recommended for use for such an examination is:

Z01.7 *Laboratory examination*

3.17.10.4. Routine examination of eyes and vision:

When a routine examination of eyes and vision is performed by optometrists or ophthalmologists, the code to use is as follows:

Z01.0 *Examination of eyes and vision*

3.17.10.5. Routine examination of newborn baby:

When a newborn baby is routinely examined, use the following code:

Z00.1 *Routine child health examination*

3.17.11. Default codes

3.17.11.1. Unspecified and default codes:

- Accounts with 'unspecified' codes that generally end in a .9 ('unspecified') or codes that generally end in a .8 ('other specified') or Sign and/or Symptom codes that begin with the letter 'R' may not be rejected by medical schemes and administrators since these are valid codes for use, both in the primary and secondary positions because they form part of the full WHO list of ICD-10 codes. These codes are also reflected as valid codes in the BHF/DXS ICD-10 Master Industry Table. (Refer to Circular 33 of 2006, Council for Medical Schemes)

- Any default codes specified by this subcommittee for use by certain specialty groups must be honoured by medical scheme and administrators. A list of the default codes and the conditions for which they can be used was published in Circular 33 of 2006 by the Council of Medical Schemes (CMS).

3.17.11.2. Default code where no abnormality is detected:

It has been established that a large proportion of claims from certain clinical support providers is for investigations, where no diagnosis is made or confirmed. As a result, the following code was recommended for use in such instances:

Z03.9: *Observation for suspected disease or condition, unspecified*.

This includes patients who present with symptoms or evidence of an abnormal condition which requires study, but who, after examination and observation, show no need for further treatment or medical care (WHO definition – refer to ICD-10 Volume 1).

3.17.11.3. Default code where no information about the external cause is available:

Healthcare providers who treat or diagnose injuries (S or T codes) but who do not come in contact with the actual patient to be able to enquire of the circumstances surrounding their injuries, may use the following secondary code as an External Cause Code (ECC):

Y34.99: *Unspecified event, undetermined intent, unspecified place, during unspecified activity*

3.17.11.4. Default code for Rule D: Cancellation of appointments:

Rule D from the healthcare providers coding structure (DBM/NHRPL) regarding the cancellation of appointments, is used in cases where a patient did not report for a procedure or consultation, but for which the provider is still entitled to bill the patient. Note that this would typically be a private account as most medical schemes do not reimburse for services not carried out. The word "procedure" in the description is deemed to refer to all "medical services" including consultations.

The following ICD-10 codes are accepted when Rule D is used as explained above:

Z53.2 *Procedure not carried out because of patient's decision for other and unspecified reasons*

Z53.8 *Procedure not carried out for other reasons*

Z53.9 *Procedure not carried out, unspecified reason*

3.17.11.5. Default code for death:

The Task Team standard code to indicate 'death' is R99: *Other ill-defined and unspecified causes of mortality* when no other cause of death is indicated.

Please note that R99 may not be the most appropriate for morbidity coding and is used more commonly in mortality coding. However, code R99 will be maintained as the morbidity "death" default code in the interim, until another solution becomes viable. Code R99 is most commonly used by Stats SA to indicate mortality on death records.

3.17.12. South African-specific U-codes

The following procedure needs to be followed if additional codes need to be added to the WHO ICD-10 structure: Identify the need; document it formally and refer it to the ICD-10 Task Team; ICD-10 Task Team tables it for discussion; if accepted, standards will be set; and the decision will be communicated to the industry.

Thus far the following set of additional ICD-10 codes was developed, that are unique to South Africa, for use in the local healthcare environment. This was done in accordance with the WHO guidelines, and in consultation with the WHO.

3.17.12.1. Non-disclosure of clinical information:

The following U-codes for non-disclosure were accepted by the WHO:

U98: *Non-disclosure*

U98.0: *Patient refusal to disclose clinical information*

U98.1: *Service provider refusal to disclose clinical information*

These above mentioned codes will be carefully profiled by medical schemes.

It should be noted that medical scheme entitlements are based on diagnosis and procedures which determine the appropriate level of reimbursement for each benefit. Thus if a patient or the healthcare provider fails to divulge diagnostic information, the scheme might sometimes not be able to determine whether the patient is entitled to the benefit being claimed for. The scheme will therefore have the right not to fund certain services for which diagnostic information is not divulged.

Code U98:1 *Service provider refusal to disclose clinical information* should never be used by pathologists as it is inappropriate for their purposes.
Code Z76.9 *Person encountering health services in unspecified circumstances* is the appropriate code for use by pathologists, radiologists and pharmacologists etc. in the absence of a referral diagnosis.

3.17.12.2. Drug resistant tuberculosis unique to South Africa

A situation unique to South Africa exists for which the WHO ICD-10 does not make provision and that is for the coding of drug resistant tuberculosis. A specific set of codes for this purpose was created and it was accepted by the WHO for use in South Africa.

The following U50.- codes must accompany codes from A15.-, A17.-, A18.-, and A19.- where bacteriological confirmation of aetiology has been established and site of disease is stated. The appropriate code(s) selected from A15.-, A17.-, A18.- or A19.- should be used as primary codes followed by the appropriate U50.- code.

U50.0 *Multi-drug resistant tuberculosis (MDR TB)*
U50.00 *Primary multi-drug resistant tuberculosis (MDR TB)*
U50.01 *Secondary multi-drug resistant tuberculosis (MDR TB)*

U50.1 *Drug resistant tuberculosis, resistance to isoniazid (INH) only*
U50.10 *Drug resistant tuberculosis, primary resistance to isoniazid (INH) only*
U50.11 *Drug resistant tuberculosis, secondary resistance to isoniazid (INH) only*

U50.2 *Drug resistant tuberculosis, resistance to rifampicin only*
U50.20 *Drug resistant tuberculosis, primary resistance to rifampicin only*
U50.21 *Drug resistant tuberculosis, secondary resistance to rifampicin only*

U50.3 *Drug resistant tuberculosis, resistance to isoniazid (INH) and rifampicin and any other anti-tuberculosis drug*

U50.30 *Drug resistant tuberculosis, primary resistance to isoniazid (INH) and rifampicin and any other anti-tuberculosis drug*

U50.31 *Drug resistant tuberculosis, secondary resistance to isoniazid (INH) and rifampicin and any other anti-tuberculosis drug*

U50.4 *Drug resistant tuberculosis, resistance to isoniazid (INH) and rifampicin and any drug not classified as an anti-tuberculosis drug, including antibiotics, anti-leprotics, etc.*

U50.40 *Drug resistant tuberculosis, primary resistance to isoniazid (INH) and rifampicin and any drug not classified as an anti-tuberculosis drug, including antibiotics, anti-leprotics, etc.*

U50.41 *Drug resistant tuberculosis, secondary resistance to isoniazid (INH) and rifampicin and any drug not classified as an anti-tuberculosis drug, including antibiotics, anti-leprotics, etc.*

U50.9 *Drug resistant tuberculosis, drug unspecified*

U50.90 *Drug resistant tuberculosis, primary resistance to drug, unspecified*

U50.91 *Drug resistant tuberculosis, secondary resistance to drug, unspecified*

3.17.13. Coding standards for specific discipline groups

3.17.13.1. Dentistry standards

- Z46.3: *Fitting and adjustment of dental prosthetic device* is specific to the dental profession and may be used alone if a visit is purely for this purpose or may be used in the secondary position with a clinical code such as 'missing teeth' in the primary position.
- For the re-cementation of a crown/bridge or for repair of a denture use Z46.3: *Fitting and adjustment of dental prosthetic device.*
- For sports mouth guard use Z29.8: *Other specified prophylactic measures*. A sports mouth guard e.g. a boxer's gum guard, is used as a prophylactic measure and is designed to stop teeth from breaking during sports activities.
- For the fracture of a post of a crown onto a tooth use T88.8 *Other specified complications of surgical and medical care, not elsewhere classified*. A post, in dental terms, is a cylindrical rod which is inserted into the prepared root of a tooth (which must have been previously root treated) with the purpose of stabilising a super structure (like a crown or filling).
    - If the external cause code (ECC) is a sequelae, use:

SDX - Y88.2: *Sequelae of adverse incidents associated with medical devices in diagnostic and therapeutic use*.

- o If the external cause code (ECC) is not a sequelae, use:

  SDX - Y84.8: *Other medical procedures* [Y84.- *Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure*].

- For numbness of tongue use R20.8: *Other and unspecified disturbances of skin sensation* even though the description indicates 'skin'.

3.17.13.2. Optometry standards:

- For frames sold without lenses being fitted use code Z41.9: *Procedure for purposed other than remedying health state, unspecified.*
- For repairs and adjustments to applications, for example spectacles, use code Z46.0: *Fitting and adjustment of spectacles and contact lenses.*
- For repeat prescription for spectacles use code Z76.0: *Issue of repeat prescription.*
- For binocular vision therapy, use: Z50.6: *Orthoptic training*
- For lenses that are treated for various purposes use code Z41.8: *Other procedures for purposes other than remedying health state.*

3.17.13.3. Pharmacy standards

- When no ICD-10 code is presented on a script, use code Z76.9: *Person encountering health services in unspecified circumstances.*
- For telephone scripts or when preventive/prophylactic medications are issued, use Z76.8: *Persons encountering health services in other specified circumstances.*
- For pharmacy advised treatment (PAT) or claimable over-the-counter (OTC) medication, the Sign and Symptom codes (R codes) could be used, if more specific information is not available. The alternative would be to use Z76.8: *Persons encountering health services in other specified circumstances* if no diagnostic information is available.
- For glucose, urine, or peak flow screening tests use Z13.8: *Special screening examination for other specified diseases and disorders* unless the screening test is done for a specific diagnosis, for example, glucose screening test for diabetes would be coded to Z13.1: *Special screening examination for diabetes mellitus*.
- For monitoring of blood pressure, use Z01.3: *Examination of blood pressure*.

3.17.13.4. Radiology standards

The following ICD-10 codes are used for radiology examinations for use as described:

- For emergency radiology performed and for which the actual x-ray is not available for reporting/diagnosing purposes use Z01.9 *Special examination, unspecified.*
- When a finding and a routine x-ray needs to be indicated, the finding is coded in the primary position and the routine x-ray coded in the secondary position. Example: When a routine chest x-ray reveals no abnormalities, code the NAD first followed by the chest x-ray:

  PDX: Z03.9 *Observation for suspected disease or condition, unspecified*

  SDX: Z01.6 *Radiological examination, not elsewhere classified*
- For after-hours radiological investigations use Z01.8: *Other specified special examinations*.
- If a patient is in a coma and can not give consent for radiological intervention use R40.2: *Coma, unspecified* or any other code indicating the signs and/or symptoms that are necessitating the investigation.
- If a minor requires radiological investigation for which he/she can not give consent use Z01.6: *Radiological examination, not elsewhere classified*.

3.17.13.5. Blood bank and blood transfusion services standards

- The most appropriate ICD-10 codes for screening tests as used by the blood transfusion services and to dispatch blood and blood products are as follows:
  - Z76.8 *Persons encountering health services in other specified circumstances*
  - Z76.9 *Persons encountering health services in unspecified circumstances*
- The ICD-10 code to use to transport blood is:
  - *Z51.3* *Blood transfusion without reported diagnosis*

    with the appropriate NHRPL code to indicate that blood was transported.
- In the absence of a confirmed diagnosis and therefore an ICD-10 code, blood banks should use:
  - Z51.3 *Blood transfusion without reported diagnosis* to issue blood to hospitals. It was also confirmed that the hospital should not be responsible for provision of an ICD-10 code to the blood bank and that code Z51.3 should be used at the blood bank's point of service, unless another diagnosis is known, then that appropriate code should be used.

3.17.13.6. Coding standards for supporting groups (Radiology, Pathology, Anaesthesiology, etc)

The issue of allowing certain portions of a specialty group to code and others not was discussed e.g. histopathologists can diagnose, but general pathologists may have difficulty in doing so. The requirement for the inclusions of a diagnostic code on claims submitted to medical schemes or

claims given to members for submission to medical schemes, applies to both the diagnosing and non-diagnosing providers. The Medical Schemes Act does not distinguish between the two groups of providers therefore all healthcare providers have to reflect ICD-10 codes on their accounts.

3.17.13.7. Anaesthesiology standards

Unless the anaesthesiologist actually makes a diagnosis while they are performing the anaesthetic, or if they act as the primary treating clinician, e.g. ventilated patients, pain control, they should use the principal surgeon's ICD-10 code on their accounts. Thus they have to, from Phase 3, supply diagnostic codes on their accounts. The diagnosis from the referring healthcare provider or from the hospital's record can be used by anaesthesiologists to determine the ICD-10 code(s) for anaesthetics performed. Sign and Symptom codes would be appropriate when for instance an MRI and colonoscopy diagnostic procedures are done under sedation and the diagnosis has not been confirmed yet until a definitive diagnosis is established.

3.18. Coding decisions taken by the subcommittee following queries

3.18.1. Non-insulin dependant diabetic classification for ICD-10

There is currently no appropriate ICD-10 classification for non-insulin dependent diabetic patients who occasionally require insulin therapy. In the current ICD-10 classification, the patient may only be coded as non-insulin dependant.

With regards to the classification of a diabetic patient who is non-insulin dependant, but who receives insulin periodically as part of their treatment regime, international information received assisted the subcommittee to conclude that E11.- *Non-insulin-dependent diabetes mellitus* (to be specified to the appropriate 4th character) be used as the South African standard to indicate the patient is non-insulin dependant.

3.18.2. Sinobronchitis

No combination code exists in ICD-10 for the coding of sinusitis and bronchitis thus these two conditions may: 1) be coded separately (with bronchitis as the primary diagnosis); or 2) according to correct WHO rules where it would be appropriate to code to the 'lowest' anatomical area affected, i.e. the bronchi, thus bronchitis would be the correct code.

Option 1:

PDX: J20.9 *Acute bronchitis, unspecified*

SDX: J01.9 *Acute sinusitis, unspecified*

Option 2:

PDX: J20.9 *Acute bronchitis, unspecified*

3.18.3. Osteopaenia

The ICD-10 code to use for osteopaenia in the primary position is M85.8: *Other specified disorders of bone density and structure* with the appropriate 5th character.

3.18.4. Necrotising fasciitis

Until such time when necrotising fasciitis is coded by the WHO, code M72.5: *Fasciitis, not elsewhere classified* is used in the primary position with an option to include a code for the causative organism in the secondary position, if known.

3.18.5. Diarrhoea and gastroenteritis of presumed infectious origin

For infective or unknown diarrhoea and gastroenteritis use A09: *Diarrhoea and gastroenteritis of presumed infectious origin*.

For non-infective diarrhoea and gastroenteritis use K52.-: *Other noninfective gastroenteritis and colitis* with the appropriate 4th character to be added.

3.18.6. Consultation, taking patient history from a family member

The ICD-10 code to use where a psychologist is getting a history from e.g. a parent, regarding a child or family member – thus the patient is not actually present during the consultation is Z71.0 *Person consulting on behalf of another person*

3.18.7. Supplying wheelchairs

Z-codes are seldom used in the primary position; therefore, the primary condition treated must be referred to in the primary position. E.g. use of a wheelchair should be coded with the clinical need for the equipment (e.g. paraplegia) in the primary position and only when no clinical information is available, should the Z-codes be used in the primary position.

For supplying a wheelchair the following ICD-10 code should be used:

Z46.8 *Fitting and adjustment of other specified devices*

3.18.8. School readiness test

The most appropriate ICD-10 code for a school readiness test is as follows:

Z02.0 *Examination for admission to educational institution*

3.18.9. Where an elderly patient needs chest physiotherapy prior to surgery

Use the following codes when an elderly patient needs chest physiotherapy prior to surgery:

Z50.1 *Other physical therapy* is appropriate for prophylactic chest physiotherapy

R54 *Senility*

The inclusion terms of code R54 include 'old age' and this code should be used as an indicator of pre-operative chest physiotherapy in an elderly person. The use of R54 should be at the physiotherapist's discretion when a patient is elderly and frail. If more is known about an actual condition that the patient is suffering from, it should be coded where it is a requirement for the treatment.

3.18.10. Coding of atypias and dysplasias

Atypias will be coded with R codes only.

Dysplasias will be coded with the disorder codes in the primary position and the R codes in the secondary position.

3.18.11. Coding rules for P-codes

- P-codes are used to classify neonatal conditions and conditions that have their origin in the perinatal period.
- P-codes can be used for adults to indicate conditions that originated in the perinatal period but presented later in life. The standard in this instance will be to use the P code in the secondary position.

3.19. ICD-10 Quick Reference Code (QRC) lists

The terms 'short lists' and 'cheat sheets' have been replaced by "ICD-10 Quick Reference Code list".

3.19.1. The development of Quick Reference Code Lists for ICD-10

Accurate coding of diagnoses is important in order to describe health conditions accurately, to reimburse healthcare providers appropriately and to collect proper epidemiological data on

healthcare patterns in South Africa. For this reason, the use of Quick Reference Code (QRC) lists (shortened lists of ICD-10 codes) is not recommended. However, the ICD-10 Implementation Task Team is aware that there are many healthcare providers who are using shortened lists of ICD-10 codes within their businesses and practices. The ICD-10 Implementation Task Team has therefore set guidelines regarding the correctness, structure and maintenance of these lists.

The Technical Subcommittee of the ICD-10 Implementation National Task Team undertook to review and ratify any ICD-10 Quick Reference Code lists that were prepared, taking these guidelines into account (This review and ratification process ended in June 2006). The subcommittee's work in assisting groups during the preparation of such lists, aimed to ensure that a standard is maintained which aligns both with the WHO standards for ICD-10 and with the national goals for diagnosis coding.

3.19.2. Principles of ICD-10 Quick Reference Code lists

- The Task Team will only validate QRC lists created by organisations, associations, societies, individuals, etc.
- The Task Team will only validate the lists with respect to code structure and standards (local, international and WHO copyright) and not for clinical appropriateness of the codes on the lists.
- The lists submitted should have the following specifics already in place:
  - Full, complete description as per WHO copyright standards
  - Codes should all be at maximum level of specificity
  - Dagger and asterisk symbols should be displayed.
- Clarification of the WHO's copyright in respect of reflecting codes and their descriptions exactly as stipulated in the ICD-10 books – if descriptions are changed or abbreviated in any way, a separate license needs to be applied for to the WHO.
- QRC lists should only contain codes that are applicable to that speciality. It is not necessary to include the whole range of codes within a 3-character category, thus the appropriate codes from the 3-character category can be selected as applicable.
- The QRC lists should include a page of guidelines/recommendations/standards (e.g. for combination coding) as determined by the Task Team to assist users in coding as accurately as possible.
- The difference between diagnosis (ICD-10) and procedure (NHRPL) codes needs to be clearly stated when the information is communicated.

- A disclaimer has to be added to all documentation reviewed by the Committee to indicate that the ICD-10 codes were verified as correct but the application of the codes was not part of the verification process.
- No QRC lists may be sold by any party unless express permission has been obtained through separate licensing for this purpose with the WHO.
- It should be clearly indicated on QRC lists that the codes on the list are a subset of the full list of ICD-10 codes and that additional codes may be applicable outside of those listed.
- Lists must clearly indicate which codes are not permissible for use in the primary position and also where combination coding is required.
- "ICD-10 Quick Reference Code lists" is the name to be used for "short lists" or "cheat lists".
- A disclaimer must be included on every Quick Reference Code list to indicate the intention of the list is a guide only and that the full ICD-10 volume must be referenced when making a final diagnosis. It also needs to be clear that these lists do not replace the strong recommendation for attending ICD-10 coding training and that there is a legal obligation on the provider to include accurate ICD-10 codes on all accounts. The disclaimer must also include a note about the validation of the codes by the Technical Subcommittee in respect of code format and not in respect of correct clinical application of the codes.
- The 'covering page' to all Quick Reference Codes lists must contain notes on:
  - Need to use ICD-10 books
  - Lists may not be sold
  - Format of lists
  - Disclaimer (as detailed above)
  - Legal obligation of provider in respect of diagnosis coding
  - Training recommendation
  - Combination coding
  - Primary and secondary code rules/definitions (align to Circular 32 of 2005, Council for Medical Schemes)
  - Allow space at bottom of lists for additions
- The Quick Reference Code lists should be developed by associations before submission to the Technical Subcommittee for review.
- Refer to the Council for Medical Schemes' Circular 23 of 2006 for more information about the development and use of Quick Reference Code Lists for ICD-10.
- The Technical Subcommittee ended all reviews of QRC lists at the end of June 2006; though assistance will still be given by the subcommittee after that date.

3.19.3. Requirements for a Quick Reference Code list

- No WHO copyright infringement may occur.
- The preamble to a published list should clearly stipulate that the list is not exhaustive.
- A QRC list does NOT and can never replace the full three volumes of ICD-10 coding.
- A QRC list does NOT and can never replace ICD-10 training.
- The format of the QRC lists should be as defined below.
- The QRC list should include a record of the review process, plus the Technical Subcommittee's disclaimer.
- QRC lists may not be sold by any party, unless express permission has been obtained through a separate individual license agreement with the World Health Organisation (WHO).
- A QRC list should include at least 10 blank spaces for a provider to add his / her own additional codes that may be required in his / her own practice.
- The QRC lists should be reviewed annually by the ICD-10 Technical Subcommittee.
- The list must include a flag or other identifying tool to ensure that users can distinguish between primary and secondary codes, together with an explanation on how these codes should be used and in what order they should appear on a claim.

3.19.4. Quick Reference Code list format

ICD-10 code descriptions appearing on the Quick Reference Code lists should conform to the descriptions as per the BHF/DXS ICD-10 Master Industry Table contained on the Board of Healthcare Funders' (BHF) CD.

The ICD-10 Technical Subcommittee found that either of the following two formats conforms to the above requirement:

Three column format:

In the 3-column format of QRC lists, the first column contains the actual ICD-10 code, the second column includes the complete WHO descriptor of that ICD-10 code and the third describes the circumstances or own references in which the ICD-10 code should be used.

ICD-10 Code/s	ICD-10 descriptor from WHO (complete descriptor)	Own reference/ Interpretation/ Circumstances in which these ICD-10 codes are to be used

Example 1:

ICD-10 Code/s	ICD-10 descriptor from WHO (complete descriptor)	Own reference/ Interpretation/ Circumstances in which these ICD-10 codes are to be used
M47.82	Other spondylosis; cervical region	SPONDYLOSIS - CERVICAL
M47.86	Other spondylosis; lumbar region	SPONDYLOSIS - LUMBAR
M47.99	Other spondylosis; site unspecified	SPONDYLOSIS - UNSPECIFIED

Two column format:

The first two columns would be the same as those in the 3-column format of QRC lists; however the last column may be excluded if desired. This may be the format of choice for healthcare provider groups or individuals compiling QRC lists.

ICD-10 Code/s	ICD-10 descriptor from WHO (complete descriptor)

Example 2:

ICD-10 Code/s	ICD-10 descriptor from WHO (complete descriptor)
Y60.0	Unintentional cut, puncture, perforation or haemorrhage during surgical and medical care; During surgical operation
Y60.1	Unintentional cut, puncture, perforation or haemorrhage during surgical and medical care; During infusion or transfusion

Dual coding

Dual coding should be accommodated on the QRC lists where e.g. dagger (+) and asterisk (*) codes should be supplied together in the same block/line to show that they are used together.

Example 3:

ICD-10 Code/s	ICD-10 descriptor from WHO (complete descriptor)	Own reference/Interpretation/ Circumstances in which these ICD-10 codes are to be used
A17.0+; G01*	Tuberculous meningitis (G01*); Meningitis in bacterial diseases classified elsewhere	TB meningitis

3.19.5. Availability of approved Quick Reference Code lists

Contact details of the persons or groups whose QRC lists were approved by the ICD-10 Technical Task Team will be available on the Council for Medical Schemes' website (www.medicalschemes.com). The Task Team decided not to place the complete QRC lists on the CMS website since concerns were raised about: 1) potential manipulation and abuse of lists once utilised off the website; and 2) even though QRC lists exist for different provider/specialist groups, they may be used by providers for whom they may not have been explicitly intended.

3.19.6. ICD-10 disclaimer on Quick Reference Code lists

The aim of placing a disclaimer on the QRC lists (and any other documents produced by the Task Team and its subcommittees) was primarily to protect the Technical Subcommittee from being held liable for the clinical application of the ICD-10 codes by individual providers. All QRC lists that have had any changes made to them by their societies since being validated by this subcommittee need to be rechecked and the disclaimer applied. The ICD-10 QRC disclaimer should appear on all pages of the QRC lists and not just on a front cover and that it should indicate the version, number of pages and date that are applicable to the disclaimer within the QRC lists. It was further recommended that guidelines with regard to ICD-10 code format and standards should be included in the disclaimer.

ICD-10 full disclaimer:

"The information contained in this document and on the ICD-10 Portal of the Council for Medical Schemes website (www.medicalschemes.com) is developed and compiled by the ICD-10 Implementation Task Team and is accordingly copyright to the ICD-10 Implementation Task Team. Any unauthorised dissemination of the information is strictly prohibited. The information may not be used without permission and without acknowledgment to the ICD-10 Implementation Task Team and may not be sold.

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3.20. Submission of claims

The following are principle decisions made by the Committee in terms of the submission of claims:

- All healthcare providers, diagnosing and non-diagnosing, are required by law to provide diagnosis code(s) on all claims submitted to a medical scheme or provided to a member(s) for submission to a medical scheme for reimbursement.
- If the diagnosis of the first person treating the patient and that of the second person either treating the patient or doing special investigations differ, no one would be compromised since coding can be done by different sources/service providers at different stages/levels of care.
- Supplying of diagnosis codes on accounts is not limited to healthcare providers in private practice but also includes persons rendering their own accounts. Refer to the second bullet point, above.
- All ICD-10 diagnostic coding will be performed as per the World Health Organisation's official rules and conventions. Specific deviations will be investigated if necessary.
- Matching the diagnosis and treatment should not become prescriptive in nature. It will be up to each individual medical scheme to profile healthcare providers using treatment that differs from the norm.
- In any situation in which a definitive diagnosis is not made, a Sign and/or Symptom code would be appropriate for use.
- South Africa is to stay with the ICD-10 diagnostic coding schema for the foreseeable future.

3.21. List of companies participating in the Technical subcommittee

The names of the persons representing the company have been omitted to ensure that when the representatives of companies change the participation of the companies are recognised.

REPRESENTING COMPANY	REPRESENTING COMPANY
Africode	Medikredit
Arista Training	Meditech SA
BestMed	Medscheme
Board of Healthcare Medical schemes	MHG
Cheiron Health Technologies	MHG/Qualsa
Council for Medical Schemes	MHS
Community Health	Mimed
Compensation Commission	MXHealth
Council of Medical Schemes	Netcare
CPS IT Committee (Pharmaceutical)	Netcare 911
CPS IT Pharmasoft	NHN
Denvision	Old Mutual Healthcare

Department of Health	Pharmaceutical Society of SA
DH Switch	Prime Cure
DHS	Promed
Discovery Health	Radpac
Donald Gordon Medical Centre	SA Dental Association
DXS	SA Medical Association
ER24	SA Military Services
FPD Trainer	SA National Blood Services
Healthbridge	SA Optometry Association
HPCSA	SAACP
Knowledge Objects	SAMCC/MHS
Lancet Labs	SAMHS
Life Healthcare	SAPAESA
Mastermed	SITA
MedCode Training and Consulting	Solutio Health Risk Management
Medcodelink	Solutio Hospital Management
Med-e-Mass	Sovereign Health
Medical Research Council	Spectramed
Mediclinic	SpesNet
Medi-Clinic Tshwane	Status M A Admin
Medihelp	Switch

4. REPORT OF THE TRAINING SUB-COMMITEE

4.1. Terms of reference

The Training Subcommittee has been tasked with the following responsibilities:

- To develop minimum training standards for ICD-10
- These include standards around:
    - Training: NQF aligned
    - Training material: NQF aligned
    - Levels of training: basic, intermediate, advanced
    - Training of multiple coding systems-sub-sets
    - Certification
    - Trainer qualification / requirements
    - List of coding training companies and coding trainers

4.2. Shortcomings and challenges

- Clinical coding training is not yet a recognised course in South Africa and is not offered at Academic Institutions. There are no registered unit standards for ICD-10 training.
- Clinical coding training is in certain instances provided informally by training institutions and trainers-some of whom have had very little exposure to coding.
- There are very few internationally accredited professional coders in South Africa.
- Many persons responsible for capturing and assigning of codes are not clinically trained; some may have some clinical experience.
- There is no Clinical Coding Body or Association in South Africa to deal with coding issues and standards.
- It is difficult for companies and practices to take staff out of the work environment for a number of days and send them for training. This would impact negatively on their businesses.
- Training standards need to be in place as soon as possible as there are time constraints for the actual training.

Following discussions, it was decided that existing training and coding processes that are in place must not be discontinued as this will slow down the implementation process, if not halt it all together. This meant that trainers and companies that are providing coding training must continue to do so; however, they must concurrently familiarise themselves with the documented standards and take appropriate steps in attaining appropriate knowledge, skills and qualifications.

Coders who are currently coding clinically trained or not, must continue to do so, however, they must concurrently take appropriate measures to attain the appropriate knowledge, skills and or qualifications.

In light of the above, it was decided by members of the task team, that in setting minimum training standards, the training subcommittee must be sensitive to the above.

4.3. Macro objective of the Training subcommittee

- To have ICD-10 training standards for South Africa (SA) that are aligned to International Coding Training Standards and to the World Health Organisation (WHO) Training Standards.
- To have an ICD-10 training standards policy document for South Africa that all healthcare stakeholders can have access to.

4.4. Minimum recommended ICD-10 basic training standards

4.4.1. Morbidity Coding

This training will have two target groups and the minimum recommendations are as follows:

4.4.1.1. Target Group 1: Non-clinically trained personal

This training is aimed at nursing assistants and staff who have no clinical qualification or equivalent clinical experience

Course duration: 3 days (24 hours)
Day 1: Basic medical terminology and anatomy (Note: Medical terminology course must take place two to four weeks prior to the ICD-10 course)
Days 2 and 3: Basic ICD-10 training

Outcomes for the Introduction to ICD-10:
At the end of this training course, learners should have an understanding of or the ability to:

- Basic medical terminology
- Basic anatomy
- Background to ICD-10 internationally and in South Africa
- The legal requirements surrounding ICD-10 in South Africa
- The benefits and uses of ICD-10, especially in the South African Healthcare environment
- An introduction to mortality coding-to create an awareness of mortality coding
- The use of volumes 1 and 3 and introduction to volume 2
- Identify ICD-10 codes
- The use of ICD-10 codes at 3, 4 and 5th character levels
- The basic structure and principles of ICD-10 according to the WHO

- All the basic rules and conventions of ICD-10 according to the WHO
- To assign ICD-10 diagnostic codes up to a basic level -this involves code assignment for single conditions and the application of the combination coding rules
- To do discipline specific coding of single conditions and apply the combination coding rules
- Understand the definitions of principal, primary and secondary diagnoses and apply these in sequencing of codes

4.4.1.2. Target group 2: Clinically Trained Personal

This course is aimed at Enrolled nurses, Registered Nurses, Medical Doctors and any other personnel who have clinical qualification or equivalent clinical experience in which they are competent with the application of basic medical terminology and anatomy.

Course duration: One day (8 hours)

Outcomes for the Introduction to ICD-10:

At the end of this training course, learners should have an understanding of or ability to:

- The background to ICD-10 internationally and in South Africa
- The legal requirements surrounding ICD-10 in South Africa
- The benefits and uses of ICD-10, especially in the South African Healthcare environment
- An introduction to mortality coding-to create an awareness of mortality coding
- The use of volumes 1 and 3 and introduction to volume 2
- Identify ICD-10 codes
- The use of ICD-10 codes at 3, 4 and 5^{th} character levels
- The basic structure and principles of ICD-10 according to the World Health Organisation (WHO)
- All the basic rules and conventions of ICD-10 according to the WHO
- To assign ICD-10 diagnostic codes up to a basic level -this involves code assignment for single conditions and the application of the combination coding rules
- To do discipline specific coding of single conditions and apply the combination coding rules
- Understand the definitions of principal, primary and secondary diagnoses and apply these in sequencing of codes
- To assign ICD-10 codes for more complex medical cases and apply the sequencing rules accurately

Coders wishing to fully understand coding of complex cases, will however be required to attend the Intermediate and Advanced ICD-10 courses

4.4.2. Basic Mortality Coding

Pre-requisite:

Basic medical terminology and anatomy

Completion of the basic ICD-10 morbidity course

Target Group: This course is aimed at all healthcare providers who are issue death certificates, Statistics South Africa, coders wishing to pursue coding as a career and Coding Trainers

Course duration: 8 hours

Outcomes for the course:

At the end of this training session, the healthcare provider should have an understanding of:

- The background to mortality coding internationally and locally
- The legal requirements surrounding mortality coding in South Africa
- Importance and uses of mortality coded data
- General uses of mortality coded data e.g. planning and evaluating health services and programs, medical and public health research, clinical education etc
- Specific uses of mortality coded data e.g. health situation and trend analysis, epidemiological surveillance, evaluation in health etc
- Users of mortality data e.g. Epidemiologists, Statisticians etc
- Sources of Mortality Data
- The rules and conventions of mortality coding
- The use of volumes 1, 2 and 3
- Applying the sequencing rules to mortality coding
- The concept of “underlying cause of death”
- Quality Assurance
- Use of the Mortality Data System Decision Tables to select the underlying cause of death
- Use of the mortality data system (currently in use for South Africa)

4.5. Training Material

- Must be outcomes based and NQF aligned as best as possible as currently there are no unit standards for ICD-10 training
- Trainer must apply the training cycle when developing materials
- The WHO Collaboration Centre has certain standards in place for ICD-10 training material that SA can adopt, if possible.

4.6. ICD-10 Complete Coding Course recommendations

4.6.1. Anatomy, Physiology and Medical Terminology (Non-medically trained staff)

Basic training standards have been set (24 hours currently), however learners will require more in-depth training that will include pathophysiology and some pharmacology.

Suggested hours of training: 144 hours of theory and summative assessments. 24 hours of facilitator based training and 120 hours of summative assessments (portfolio of evidence [POE])

4.6.2. Introduction to Basic ICD-10 Training

Basic standards have been set for 8 hours. This is not sufficient as not enough practical applications are done during this period.

Suggested hours of training: 88 hours (8 hours of facilitator based training and 80 hours of summative assessment-to be done at the learners pace in his or her own time)
Please suggest unit standards as per the current standards set.

4.6.3. Intermediate ICD-10 Training

Suggested hours of training: 88 hours (32 hours of facilitator based training and 56 hours of summative assessment (POE) to be done at the learners pace in his or her own time)

<u>Suggested Course Content</u>
Understanding of all general notes, glossary descriptions, relational terms (everything that is not discussed in the basic course)
Combination Coding:

- Dagger and asterisk: complete use, including understanding of the three forms in which they appear
- Coding of infectious diseases that require additional codes
- Coding of neoplasms-functional activity and additional morphology code (not the complete training on ICD-1O

Coding of minor versus more significant conditions
Coding of comparative and contrasting diagnoses
Coding of several conditions that meet the criteria for primary diagnosis-intermediate level
Coding of acute versus chronic conditions
Coding of query, unknown and uncertain diagnoses
Coding of post procedural complications

Coding of poisoning and adverse reaction

Multiple coding guidelines

SA specific coding guidelines-refer learners to the technical standards document

Introduction to basic rules of all 21 chapters

4.6.4. Advanced ICD-10 Training

Suggestions

Course duration: 360 hours

Split into: 9 modules

Each module will entail 8 hours of facilitator based training and 32 hours of self-learning in the form of assignments/ summative assessments.

There will numerous unit standards within each module

Suggested Course Content

Module 1: Advanced coding rules of:

- Infectious and parasitic diseases
- Neoplasms, includes-ICD for oncology

Module 2: Advanced coding rules pertaining to:

- Diseases of the blood and blood-forming organs
- Endocrine, metabolic and nutritional disorders

Module 3: Advanced coding rules pertaining to:

- Mental and behavioural disorders
- Nervous system disorders

Module 4: Advanced coding rules pertaining to:

- Diseases of the eye and adnexa
- Diseases of the ear
- Diseases of the circulatory system

Module 5: Advanced coding rules pertaining to:

- Diseases of the respiratory system
- Diseases of the digestive system

Module 6: Advanced coding rules pertaining to:

- Diseases of the skin and subcutaneous tissue
- Diseases of the musculoskeletal system

Module 7: Advanced coding rules pertaining to:

- Genito-urinary system disorders
- Pregnancy, Childbirth and the puerperium

Module 8: Advanced coding rules pertaining to:

- Congenital and chromosomal disorders
- Conditions originating in the perinatal period
- The coding of signs, symptoms and abnormal clinical and laboratory findings

Module 9: Advanced coding rules pertaining to:

- The coding of injuries, poisoning and other consequences of external causes
- The external cause of injury coding rules
- Factors Influencing Health Status and contact with Health Services

SA-specific coding guidelines and legal implications to be covered in all levels of training, including all nine advanced modules as and when required.

This means that non-clinically trained staff will require a minimum 672 hours of training to complete the ICD-10 course.

Clinically trained staff will require a minimum of 536 hours of training to complete the ICD-10 course - they must be pre-assessed in medical terminology, anatomy and physiology to get recognition for prior learning (RPL).

4.7. Assessment standards and criteria

The following assessment standards and criteria are applicable to the Basic Medical Terminology, Anatomy and Physiology and The Introduction to Basic ICD-10 Coding courses:

- Pre course assessment: to give recognition for prior learning - this must be a written assessment
- Mid-course assessment: either one or all of these: oral, written, practical exercises or observation.
- Post course assessment: written assessment

4.7.1. Assessment Criteria and Guidelines for the Medical Terminology, Anatomy and Physiology Course

Overall the assessment must include the recommendations below. A breakdown has been provided for the different levels of assessment

- 6 Assessment criteria that address Medical Terminology
- 6 Assessment criteria that addresses Anatomy
- 4 Assessment criteria that addresses Prefixes
- 4 Assessment criteria that address Suffixes
- 4 Assessment criteria that address Physiology
- 2 Assessment criteria per body system for practical exercises

4.7.1.1. Pre-assessment (Medical Terminology, Anatomy and Physiology)

Non-Medical

- 3 Medical terminology
- 3 Common medical abbreviations
- 2 Prefixes
- 2 Suffixes
- 2 Common combination terminology
- 3 Anatomy questions

4.7.1.2. Mid-Assessment

- Practical exercise e.g. Label a drawing of e.g. the human skeleton, an organ (Lung) etc
- List known conditions related to the diagram and explain or define conditions (address basic physiology)

4.7.1.3. Post-Assessment

- 3 Medical terminology
- 3 Common medical abbreviations
- 2 Prefixes
- 2 Suffixes
- 2 Common combination terminology
- 3 Anatomy questions

4.7.1.4. Summative Assessment (In a controlled environment)

(Post training, 2-4 weeks)

Questions can range from 25 - 50

- Practical questions to focus on terminology, anatomy, prefixes, suffixes and physiology

4.7.2. Assessment Criteria for the Introduction to Basic ICD-10 Coding Course

(Non-Medical)

- 2 Assessment criteria that addresses background and industry issues/legislation with regards to ICD-10
- 2 Assessment criteria that addresses uses and benefits of clinical coding

- 4 Assessment criteria that addresses rules and conventions of ICD-10 (theory)
- 4 Assessment criteria that address rules and conventions of ICD-10 (practical)
- 2 Assessment criteria per chapter for practical exercises, in other words there should be 2 practical exercises per chapter that equals 42 practical exercises in total that address the introductory course comprehensively.

4.7.2.1. Pre-Assessment (Introduction to Basic ICD-10 Coding)

Non-Medical

- 2 Industry related questions
- 2 Benefits of clinical coding
- 6 Questions on ICD-10 coding
- 3 Abbreviations used in ICD-10
- 2 Questions that address common coding errors

4.7.2.2. Mid-Assessment

- Observation on the use of Volume 1 and 3
- Observation on the understanding of a lead term
- Observation on assigning a code at a 3, 4 and 5th character level
- Code practical coding scenarios e.g. Pneumonia, Sinusitis (Acute vs. chronic), Tonsillitis, Abdominal pain, Hypertension, etc

4.7.2.3. Post-Assessment

- 2 Industry related questions
- 2 Benefits of clinical coding
- 6 Questions on the rules and conventions of ICD-10
- 2 Questions that address common coding errors
- 3 Practical examples

4.7.2.4. Summative Assessment

(Post training, within 2-4 weeks)

Questions can range from 42-50

An assessment will include:

- Practical scenarios to be coded using Volume 1 and 3
- Assessment to include the application of rules and conventions learnt
- Theoretical questions on the rules and conventions (definitions, types of combination codes etc)

4.7.3. Assessment Criteria for Introduction to Basic ICD-10 Coding (Clinically Trained persons)

- 4 Assessment criteria (AC) that address background and industry issues/legislation with regards to ICD-10
- 4 AC that addresses uses and benefits of clinical coding
- 6 AC that addresses rules and conventions of ICD-10 (theory)
- 6 AC that address rules and conventions of ICD-10 (practical)
- 2 AC per chapter for practical exercises, in other words there should be 2 practical exercises per chapter that equals 42 practical exercises in total that address the introductory course comprehensively. This can obviously be adjusted according to the target audience-if the training was done to a particular specialty group, and then the practical exercises should address that discipline and not all 21 chapters.

4.7.3.1. Pre-Assessment (Introduction to Basic ICD-10 Coding)

(Clinically trained)

- 2 Industry related questions
- 4 Benefits and uses of clinical coding
- 6 Questions on the rules and conventions of ICD-10
- 3 Questions that address common coding errors

4.7.3.2. Mid-assessment

- Observation on the use of Volume 1 and 3
- Observation on the understanding of a lead term
- Observation on assigning a code at a 3, 4 and 5th character level
- Observation on multiple coding
- Observation on combination coding
- Practical exercises e.g. Injuries with external cause code, poisoning, adverse reaction, neoplasms, pregnancy and childbirth, etc

4.7.3.3. Post-assessment

- 2 Industry related questions
- 2 Benefits and uses of clinical coding
- 6 Questions on the rules and conventions of ICD-10
- 2 Questions that address common coding errors
- 3 Practical examples

4.7.3.4. Summative Assessment

(Post Training, within 2-4 weeks)

Questions can range from 42 - 50

An assessment will include:

- Practical scenarios to be coded using Volume 1 and 3
- Assessment to include the application of rules and conventions learnt
- Theoretical questions on the rules and conventions (definitions, types of combination codes etc)

4.7.4. Assessment guideline to assess learners, in the absence of Unit Standards

0-49%: not yet competent

50-79%: partially competent

80-100%: competent

4.8. Certification

- An attendance certificate will be awarded for attendance at the Introduction to basic ICD-10 coding course
- A completion certificate will be awarded on successful completion of all the assessments and once the learner has been deemed competent by the trainer/facilitator, for the Introduction to basic ICD-10 coding course.
- All healthcare providers who qualify for C.P.D points will be awarded C.P.D points on completion of all the coding courses.

4.9. Pre-Course Study Guide

The members of training-subcommittee working group decided that each learner needs a pre-course study guide in the form of a Medical Workbook for introduction to Medical Terminology, Anatomy and Physiology the following guidelines are to be used by trainers in development of the study guide:

4.9.1. Structure of the Medical Workbook

4.9.1.1. Common Medical Terminology

E.g.

Appendicitis

Fracture

4.9.1.2. Common Medical Abbreviations

E.g.

AIDS, DVT, UTI

4.9.1.3. Common Medical Prefixes

E.g.

Angi/o (vessel)

Arteri/o (artery)

4.9.1.4. Common Medical Suffixes

E.g.

-ectasis (stretching/dilation)

-ectomy (removal, excision)

4.9.1.5. Common Combination Terminology

E.g.

Hem/o/rrhage (bursting forth of blood)

Retr/o/version (to turn back)

4.9.1.6. Common Anatomical Terminology

E.g.

Positions, Sections, Regions

4.9.1.7. Anatomy and Physiology

(Structure around the 21 chapters of ICD-10)

E.g.

Chapter 1 (Certain infectious and parasitic diseases)

A15 - Respiratory tuberculosis…

Basic Anatomy of the lung

Basic Physiology of the lung

4.10. Facilitator/Trainer Requirements (Standards)

4.10.1. Medical Terminology and Basic Anatomy Trainer

- A trainer must have:

- a clinical qualification or equivalent clinical certification e.g., Nursing or Medical Degree or Diploma or a certification from a recognised institution in medical terminology and anatomy
- completed the unit standard “Plan and conduct assessment of learning”. This is a SAQA requirement for 2004.
- An appropriate training qualification e.g. RAU or Damelin Train-the-Trainer, etc.

4.10.2. Clinical Coding Trainer

- A trainer must have:
  - a completion certificate in coding (ICD-10) up to an advanced level; or an international accreditation in clinical coding; or a recognized South African coding qualification (when unit standards are registered).
  - completed the unit standard “Plan and conduct assessment of learning”. This is SAQA requirement as of 2004. (Ensure registration with the SETA).
  - an appropriate training qualification
  - trainers training the basic ICD-10 course do not need to have a clinical background; however when a trainer is training the Intermediate and Advanced ICD-10 courses, a clinical qualification or equivalent certification is necessary.

(Note: Internationally, all coders and coding trainers, in particular, have either a clinical background or formal training in anatomy, physiology and medical terminology, irrespective of level of course being trained or facilitated). In S.A. a basic coding trainer must have a clinical background or he /she must have completed 144 hours of anatomy, physiology and medical terminology or have an equivalent certification.

4.11. ICD-10 Trainers and Training companies in South Africa

4.11.1. Companies conducting external training

These are companies who provide training to external clients at a fee. They also provide training in anatomy, physiology and medical terminology.

- **Foundation for Professional Development: Basic, intermediate and advanced**
  - 012 481 2193/2031 / foundation@foundation.co.za
- **Africode: Basic, intermediate and advanced**
  - 011 884 8767 / info@africode.co.ca
- **Discovery Institute: Basic, intermediate and advanced**

    - 011 529 7015/3485 / dhinstitute@discovery.co.za
- **Medcode Training and Consulting CC: Basic, intermediate and advanced**
    - 082 606 7757/ 082 570 1021/ elaines@medcodetraining.co.za, lynetc@medcodetraining.co.za
- **IHRM: Basic, intermediate and advanced**
    - 0861 112 751 / info@ihrm.co.za

4.11.2. Companies conducting internal training

Companies and associations who provide in-house training to staff or members at no cost:

- **Life Healthcare: Basic and intermediate**
    - 011 219 9636 / Faith.barter@lifehealthcare.co.za
- **Netcare: Basic and intermediate**
    - 011 482 4321 / Erna.VanRooyen@netcare.co.za
- **Mediclinic: Basic and intermediate**
    - 021 809 6500 / sunell.lubbe@mediclinic.co.za
- **Spesnet**
    - 012 683 0356 / lee@spesnet.co.za
- **South African Dental Association**
    - 011 484 5288 / neilc@sada.co.za
- **Discovery Institute: Basic, intermediate and advanced**
    - 011 529 7015/3485 / dhinstitute@discovery.co.za
- **State Information Technology Agency: Basic**
    - 083 376 7159 / annelise.vanwyk@sita.co.za
- **MHG: Basic**
    - 021 480 4065 / vdiab@qualsa.co.za
- **Medihelp: Basic**
    - 012 334 2039/BduToit@medihelp.co.za

5. REPORT OF THE CONFIDENTIALITY SUBCOMMITTEE

The task team resolved to address the issues of confidentiality through a sub committee after it was identified as a major factor in the implementation of ICD-10. This was despite earlier attempts to resolve the issue through the Operations Subcommittee. The subcommittee on confidentiality was given full mandate to consult with all relevant stakeholders with a view to resolving outstanding issues.

5.1. Terms of Reference

This subcommittee has been tasked to document a framework, which will assure the health professionals that, by documenting the ICD-10 codes as relating to the patient, this personal health information in the form of ICD-10 codes will be secure and kept confidential.

5.2. Objectives

The objectives of the confidentiality sub committee are to:

- ensure the integrity, privacy, confidentiality and security of personal health information as it relates to ICD-10 codes across the data chain / information pathway comprising of healthcare providers, medical schemes, medical scheme administrators, managed care organisations, switching companies, data management and data transfer companies, pharmaceutical benefit management companies and any other related third parties;
- identify the manner in which informed consent to disclosure of ICD-10 codes should be obtained from patients / medical scheme beneficiaries;
- clearly define the purpose and consequences of disclosure of ICD-10 codes;
- enable the disclosure of ICD-10 codes to other healthcare service providers such as persons licensed to dispense medicine.

The confidentiality subcommittee continues with its work of developing a framework for the handling and management of patient information within the medical scheme environment. This work will culminate in a report that includes recommendations on patient information confidentiality.

6. RECOMMENDATIONS OF THE NATIONAL ICD-10 TASK TEAM

The task team recommends that the following issues be taken forward in order to take the process of implementation of ICD-10 forward.

- Formation of a National Standards Body on Health Information that will assume responsibility for the continued implementation, management and review of ICD-10. The standards body will, among others, be responsible for the following:
    - establishment of a national help desk or advice centre to deal with all ICD-10 matters
    - ensure that all relevant materials on ICD-10 are available in the country and accessible to stakeholders
    - engage the WHO with a view to securing a single license for the country
    - participate in the process to align legislative provisions on health/patient information from different sectors
    - liaise with stakeholders on all matters pertaining to ICD-10
    - review the status of non-diagnosing healthcare providers with regards to submission of ICD-10 codes
    - update the industry BHF/DXS ICD-10 Master Industry Table regularly
    - engage with the WHO on ICD-10 developments nationally, and internationally
    - develop strategies for collection of ICD-10 codes by all stakeholders in the public and private sector, particularly those outside the medical schemes environment
    - engage with SAQA and SETA to develop ICD-10 unit standards and/or engage with tertiary institutions to develop a curriculum for ICD-10 training
    - assume responsibility for the accreditation of coding trainers and coding training companies
    - assume responsibility for ICD-10 accreditation or certification
    - update and enhance ICD-10 coding training and trainer standards
    - critique coding tools and or products
    - and implementation of clinical validation.