South African ICD-10 Technical User Guide

Technical User Guide compiled by the Ministerial ICD-10 Task Team to define standards and guidelines for ICD-10 coding implementation

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Revision History

Version	Date	By Whom	Changes
Draft 1 ver 1.00	2012/08/20	Brenda Gous, Izelle van Deventer, Ronelle Smit	Document creation and incorporating all changes suggested by members of the Task Team.
Draft 2 ver 1.00	2012/08/22	Izelle van Deventer	Incorporating changes suggested by members of the Task Team.
Draft 3 ver 1.00	2012/10/18	Sithara Satiyadev, Luisa Whitelaw, Brenda Gous, Corné Vaughn	Expanding on phase 3 validations
Draft 1 ver 2.00	2013/08/10	Brenda Gous	Concerns expressed on some definitions and statements which differ from the SA Coding Standards document. Expanding on ICD-10 technical requirements regarding claim submissions
Draft 2 ver 2.00	2014/01/31	Brenda Gous Izelle van Deventer	Finalising document for publication.
Draft 3 ver 2.00	2014/02/07	Brenda Gous Izelle van Deventer	Comments received at ICD-10 TT meeting 2014/02/06. Document title change from User Guide to ICD-10 Technical User Guide.
Draft 3 ver 2.00	2014/03/19	Brenda Gous Luisa Whitelaw	Comments received.
Draft 4 ver 2.00	2014/05/15	Brenda Gous Luisa Whitelaw	New National documents compiled, discussed and accepted at the meeting held on 03 April 2014.
Draft 5 ver 2.00	2014/05/16	Brenda Gous Glenda de Beer Izelle van Deventer	Addition of Common Definitions, Acronyms and Abbreviations.

1. Introduction

1.1 Overview and Background

ICD-10 (International Statistical Classification of Diseases and Related Health Problems – Tenth Revision) is a diagnostic coding standard owned and maintained by the World Health Organisation (WHO). The coding standard was adopted by the National Health Information System of South Africa (NHISSA), and forms part of the health information strategy of the National Department of Health (NDoH). The standard currently serves as the diagnostic coding standard of choice in both the public and private healthcare sectors for morbidity coding.

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

Regulation 5(f) of the Medical Schemes Act 131 of 1998 prescribes the manner of submission of claims by healthcare providers and determines that all claims must contain "the relevant diagnostic … code … that relates to the health service". The Council for Medical Schemes (CMS) will provide assistance to the Ministerial ICD-10 Task Team (ICD-10 Task Team) and measure compliance against Regulation 5(f) of the Medical Schemes Act 131 of 1998 as part of the accreditation of managed healthcare organisations and medical scheme administrators in future

The implementation of the Medical Schemes Act 131 of 1998 also saw the emergence of a minimum set of guaranteed benefits to be covered by medical schemes referred to as Prescribed Minimum Benefits (PMBs). Entitlement to these benefits is diagnoses-driven and is appropriately identified using ICD-10 coding.

To support the National Health Insurance (NHI) and for the purpose of accurate disease statistics, a Ministerial ICD-10 Task Team has been established to advise the Minister of Health on matters pertaining to ICD-10. One of the responsibilities of this ICD-10 Task Team is to ensure that phase 3 and 4.1 of ICD-10 is fully implemented by 1 January 2014. Documentation in this regard is published on the NDoH website: www.doh.gov.za – Resource Centre – Legislation – Notices.

1.2 Objective(s)

The following table describes the main objectives of the ICD-10 Task Team's Technical User Guide:-

01.	Defining clear technical requirements to ensure easy understanding of Phase 3 implementation requirements.	
	O1.1	Ensure the equal compliance within the public and private healthcare sectors.
02.	Implementation of ICD-10 Clinical Validation.	
	O2.1	Assist in a smooth and successful transition from ICD-10 Coding Implementation Phase 3 to Phase 4.
O3.	Ensuring high compliance and accurate ICD-10 statistics by medical schemes, medical scheme administrators and managed healthcare organisations, and by default healthcare service providers in both the public and private healthcare sectors.	
	O3.1	A detailed review of the current ICD-10 compliance data will be undertaken by the Council for Medical Schemes (CMS) on behalf of the NDoH.
	O3.2	Findings of O3.1 must be analysed and reported with specific focus on the outstanding requirements of Phase 4 of the implementation process.

1.3 Acronyms and Abbreviations

Abbreviation	Term / Definition
BHF	Board of Healthcare Funders
CMS	Council for Medical Schemes
CR	Clinical Validation / Claim Rule
ECC	External Cause Codes
EDIFACT	Electronic Data Interchange for Administration, Commerce and Trading
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
ICD-10	Statistical Classification of Diseases and Related Health Problems – Tenth Revision
ICD-DA	International Classification of Diseases to Dentistry and Stomatology
ICD-O	International Classification for Oncology
ICD-10 TT	Ministerial ICD-10 Task Team
LOA	Level of Acuity
LOS	Length of Stay
MIT	Master Industry Table
MVA	Motor Vehicle Accident
NAPPI	National Pharmaceutical Product Index
NDoH	National Department of Health
NHISSA	National Health Information System of South Africa
NHI	National Health Insurance
PDX	Primary Diagnosis
PMA	Practice Management Application
PMB	Prescribed Minimum Benefits
SDX	Secondary Diagnosis
WHO	World Health Organisation

1.4 References

The following documents must be read in conjunction with each other for a complete understanding of the South African ICD-10 requirements:

- National ICD-10 Implementation Status Report for South Africa
- South African ICD-10 Morbidity Coding Standards and Guidelines
- South African ICD-10 Mortality Coding Standards and Guidelines
- ICD-10 Master Industry Table for South Africa
- User Guide for the National ICD-10 Master Industry Table for South Africa

Please refer to the National Department of Health's web site for the most up to date version of the documents listed above.

Other references:

- PHISC Guidelines on Submission of ICD-10 Codes dated August 2005

For enquiries regarding the above mentioned documents, please direct an email to ICD10@health.gov.za.

1.5 Acknowledgements

The NDoH would like to thank all role players serving on the ICD-10 Task Team for offering their time and expertise in the development of the implementation plan and supporting documentation. The NDoH would also like to extend its appreciation to Mrs Izelle van Deventer for her assistance in creating professional documentation.

2. ICD-10 Implementation Phases

A phased approach starting on 1 July 2005 has been followed to implement ICD-10 coding in South Africa as described in the CMS Circular 32 of 2005.

- Phase 1: Implementation period from 1 July 2005 to 30 September 2005
- Phase 2: Implementation period from 1 October 2005 to 31 December 2005
- Phase 3: Implementation period from 1 January 2006 to 01 July 2014
- Phase 4: Implementation has been further phased into 4.1 and 4.2.
- Phase 4.1: Implementation period starts with displaying warning messages from 01 June 2013 based on the new data requirements i.e. age and gender validations. This phase will be fully implemented on **1 July 2014** with full claim validation rejections based on the new clinical data requirements.
- Phase 4.2: Implementation details will be finalised in 2014 and communicated to all healthcare stakeholders

In order to be fully compliant with the ICD-10 coding implementation plan, stakeholders must have successfully implemented phase 3 and 4.1 by 01 July 2014

The requirements for implementation of the phases are described as follows:-

Implementation Requirements		Phase 1	Phase 2	Phase 3	Phase 4
Use all codes (primary and secondary) from the Master Industry Table (MIT)		■ (green)	■ (orange)	■ (blue)	■ (yellow)
Level of specificity of ICD-10 code(s)					
1.1	Minimum 3-characters	■ (green)			
1.2	Maximum level of specificity (3rd, 4th and 5th characters) for all primary and secondary codes		■ (orange)	■ (blue)	■ (yellow)
Sequencing of multiple ICD-10 codes					
2.1	Valid Primary code in first position, followed by secondary codes to a maximum of 10 codes per line item for Medical, Allied and Support Health Professionals and a Valid Primary code in first position, followed by a maximum of 29 codes on a header level for hospital providers		■ (orange)	■ (blue)	■ (yellow)
2.2	Codes invalid for use in first position: Asterisk, Sequelae, or External Cause Code (ECC), etc		■ (orange)	■ (blue)	■ (yellow)

Implementation Requirements		Phase 1	Phase 2	Phase 3	Phase 4
Healthcare Providers mandated to submit ICD-10 codes.					
3.1	All diagnosing healthcare providers for all claim items.				
3.2	All non-diagnosing healthcare providers (pharmacists, clinical support and allied healthcare providers) for all PMB claim items.				
3.3	All non-diagnosing healthcare providers (pharmacists, clinical support and allied healthcare providers) for all non-PMB claim items.				
3.4	Hospital claims mandated to submit on highest / header / claim level only.				
3.5	Referral diagnoses to be submitted highest / header / claim level only when available.				
ICD-10 codes per claim item.					
4.1	At least 1 code				
4.2	Full clinical encounter coding For example: two codes describing the disease or condition e.g. injuries with an ECC; irrespective of whether the injury code is in the primary or secondary position, and ECC must follow somewhere in the secondary string				
Clinical Validation					
5.1	Contractual arrangements				
5.2	PMB conditions				
5.3	ICD-10 code not appropriate for Patient age				
5.4	ICD-10 code not appropriate for Patient gender				

3. ICD-10 Terminology Definitions

Using the above mentioned table describing the requirements for implementation of the different ICD-10 phases, the following sections explain the different ICD-10 terminology in more detail.

3.1 Common Definitions, Acronyms and Abbreviations

Abbreviation / Acronym	Term / Definition
AIDS	Acquired Immune Deficiency Syndrome
BHF	Board of Healthcare Funders
CAT	Computerised Axial Tomography
CMS	Council for Medical Schemes
COIDA	Compensation for Occupational Injuries and Diseases Act
CR	Clinical Validation / Claim Rule
DG	Director General
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSN	Diagnosis Standard National
ECC	External Cause Codes
EDIFACT	Electronic Data Interchange for Administration, Commerce and Trading
GMCS	General Mortality Coding Standard
GSN	General Standard National
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HWSETA	Health and Welfare Sector Education and Training Authority
ICD-10	International Statistical Classification of Diseases and Related Health Problems – Tenth Revision
ICD-10 TT	Ministerial ICD-10 Task Team
ICD-DA	International Classification of Diseases to Dentistry and Stomatology
ICD-O	International Classification of Diseases for Oncology
LOA	Level of Acuity
LOS	Length of Stay
MIT	ICD-10 Master Industry Table
2014 MIT	2014 ICD-10 Master Industry Table

Abbreviation / Acronym	Term / Definition
MRC	Medical Research Council
MRI	Magnetic resonance imaging
MVA	Motor Vehicle Accident
NAD	No Abnormalities Detected
NAPPI	National Pharmaceutical Product Index
NDoH	National Department of Health
NHA	National Health Act
NHI	National Health Insurance
NHISSA	National Health Information System of South Africa
NHRPL	National Health Reference Price List *(referred to as such until 2010, after which, referred to as RPL)*
NTT	National ICD-10 Task Team *(this is what the previous ICD-10 Task Team was known as)*
PDX	Primary Diagnosis
PEP	Post Exposure Prophylaxis
PHISC	Private Healthcare Information Standards Committee
PMA	Practice Management Application
PMB	Prescribed Minimum Benefits
QRC	Quick Reference Code Lists
RAF	Road Accident Fund
REF	Risk Equalisation Fund
RPL	Reference Price List
SA	South Africa
SAQA	South African Qualification Authority
SDX	Secondary Diagnosis
SITA	State Information Technology Agency
StatsSA	Statistics South Africa
UCoD	Underlying Cause of Death
URC	Update Reference Committee
WHO	World Health Organisation

3.2 Master Industry Table (MIT)

The MIT is considered the healthcare industry standard for ICD-10 codes and contains all the ICD-10 codes to be used in South Africa. The MIT is distributed in both a Microsoft Excel spreadsheet and a comma-delimited (.csv) file format.

A number of versions of the MIT have been compiled since the implementation of ICD-10 as the National Standard in South Africa. These have consisted of the ICD-10 codes in a flat file for downloading onto software systems of both healthcare providers and funders. The file has recently been updated by the Ministerial ICD—10 Task Team, and the most recent version, replacing all previous versions, was published by the National Department of Health on 1 January 2014.

Implementation date for this latest version is 1 July 2014. It is available in the following formats on the National Department of Health website, (www.doh.gov.za), in order to easily be imported into the various software systems in the industry:

- Microsoft Excel (.xls)
- Comma Delimited (.csv)

Various versions of the MIT have been published:

- February 2005 (First publication)
- July 2007
- December 2012
- March 2013
- May 2013
- January 2014

The ICD-10 MIT does not replace the need for ICD-10 training, or the need to reference the three ICD-10 volumes for assigning complete and accurate coding.

Please refer to the latest version of the *South African ICD-10 Morbidity Coding Standards and Guidelines* document for details regarding the content of the MIT.

3.3 Coding Definitions

To avoid confusion and duplication of definitions already set by the ICD-10 Task Team you are referred to the latest version of the *South African ICD-10 Morbidity Coding Standards and Guidelines* document which will always contain the current and most recent definitions.

3.3.1 Primary Diagnosis (PDX) - Morbidity

You are referred to the latest version of the *South African ICD-10 Morbidity Coding Standards and Guidelines* document for the existing and most recent definition namely: GSN0001.

3.3.2 Primary Code

The primary code is the code that describes the primary diagnosis (i.e. the main condition treated), and must appear in the primary / first position on a claim.

3.3.3 Secondary Diagnosis (SDX) - Morbidity

You are referred to the latest version of the *South African ICD-10 Morbidity Coding Standards and Guidelines* document for the existing and most recent definition namely: GSN0002.

3.3.4 Secondary Code

Secondary codes are codes that further describe the patient's condition or the cause of the patient encounter. The secondary codes must follow the primary code and appear in the second to tenth position on a Medical, Allied and Support Health Professional's claim; a maximum of 29 secondary codes should be accommodated on the header level of a hospital provider's claim. Examples include diabetic retinopathy, motor vehicle accident (MVA). The rules and conventions of ICD-10 coding as set out by the WHO are applied to assign these codes appropriately.

3.3.5 Invalid Code

For an ICD-10 code to be considered valid for use it must exist in the current version of the MIT, which is in line with the latest version of the World Health Organization (WHO) errata's and amendments introduced in South Africa.

Rule #	ICD-10 Claim Rule Description
CR0001	ICD-10 codes are discontinued as per WHO decisions. When an ICD-10 code is discontinued in the South African MIT, the ICD-10 code is assigned an End Date. For example: C14.1 was discontinued on 2007/08/31
CR0002	Placeholders may be upper or lower case x / X (for example M45.x9), but must be applied when required. Please refer to the latest version of the *South African ICD-10 Morbidity Coding Standards and Guidelines* document (GSN0009). CORRECT: M45.x0 INCORRECT: M45. □0 (no spaces allowed)
CR0003	3-character ICD-10 codes: No dot (.), no spaces, no hyphens.
CR0004	4- and 5-character ICD-10 codes: No spaces, no hyphens, but include dot (.) after third character.
CR0005	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).
CR0006	Morphology codes must be catered for and the correct code format used.
CR0007	Decimal point and forward slash symbols The decimal point (.) [referred to as dot] for all fourth and fifth character codes, and the forward slash (/) for morphology for neoplasms, have been retained and should always be reflected when codes with these symbols are used.
CR0008	No spaces are allowed to follow the code or to "reserve" a field. INCORRECT: M79.□2□/I10.5□/□K53.6 (spaces)
CR0009	No special character may be submitted as part of the code. INCORRECT: M79-2/I10-5/K53-6 (no hyphens allowed) INCORRECT: (M79.2)(I10.5)(K53.6) (no brackets allowed)
CR0010	Alphabetical characters are only used as the first character for all ICD-10 codes. INCORRECT: KO1.1 (Incorrect use of capital O instead of a zero 0) INCORRECT: J01.I (Incorrect use of lower case "L" or upper case "I" instead of a one (1)) INCORRECT: 086.1 (Incorrect use of zero (0) instead of the upper case O)

3.3.6 Valid Primary Code

For an ICD-10 code to be considered a valid **primary code**, it must be reflected at the highest level of specificity ("Valid_ICD10_ClinicalUse" indicator must be 'Y') as determined by the coding rules of the WHO and the *South African ICD-10 Morbidity Coding Standards and Guidelines* document AND it must be marked as a 'Y' in the MIT column titled "Valid_ICD10_Primary".

There are certain ICD-10 codes, such as asterisks, sequelae, external cause codes etc. that are not considered valid for use in the primary (first) position as per the morbidity coding rules and conventions of the WHO and these will be flagged as an 'N' in the MIT column titled "Valid_ICD10_Primary".

"Other specified", "Unspecified", "Sign and symptom" and "Default" codes are part of the full WHO list of ICD-10 codes and are reflected in the latest electronic ICD-10 MIT. These codes are valid and cannot be rejected by medical schemes / processing parties since in some cases no more specific information is available to assign a more specific code.

(Refer to Circular 16 of 2009: *Validity of Unspecified, Other specified, Sign & Symptom, and Default ICD-10 codes*).

Examples of **valid Primary** ICD-10 codes up to maximum level of specificity:-

ICD-10 Code	ICD-10 Description	Valid as a Primary Code	Reason
M65.3	Trigger finger	NO	Code not to maximum level of specificity
M65.34	Trigger finger, hand	YES	Code is to its maximum level of specificity
N63	Unspecified lump in breast	YES	Code is to its maximum level of specificity
D63*	Anaemia in chronic diseases classified elsewhere	NO	Code is not to its maximum level of specificity AND it is not valid for use in the primary position
D63.0*	Anaemia in neoplastic disease (C00-D48+)	NO	Code is not valid for use in the primary position
D63.8*	Anaemia in other chronic diseases classified elsewhere	NO	Code is not valid for use in the primary position

3.3.7 Valid Code for Clinical Use

For an ICD-10 code to be considered valid for clinical use, it must be reflected at the highest level of specificity as determined by the coding rules of the WHO and the *South African ICD-10 Morbidity Coding Standards and Guidelines* document. This would involve primary and secondary codes. This is referenced to the MIT column titled as: "Valid_ICD10_ClinicalUse" and most recent definition namely: GSN0004.

Example of **valid Primary** ICD-10 code **for clinical use** up to maximum level of specificity:-

ICD-10 Code	ICD-10 Description	Valid as a Primary Code for Clinical Use
M65.3	Trigger finger	NO
M65.34	Trigger finger, hand	YES
N63	Unspecified lump in breast	YES

Example of **valid Secondary** ICD-10 code **for clinical use** up to maximum level of specificity:-

ICD-10 Code	ICD-10 Description	Valid as a Secondary Code for Clinical Use
W01	Fall on same level from slipping, tripping and stumbling	NO
W01.0	Fall on same level from slipping, tripping and stumbling, home	NO
W01.00	Fall on same level from slipping, tripping and stumbling, home while engaged in sports activity	YES

3.3.8 Complete Code / Level of Specificity

A **complete code** is an ICD-10 code specified to its maximum level of specificity as published in the MIT as determined by the coding rules of the World Health Organization (WHO) and the *South African ICD-10 Morbidity Coding Standards and Guidelines* document. This is referenced to the MIT as: Valid_ICD10_Primary, Valid_ICD10_ClinicalUse and most recent definition namely: GSN0004.

While most ICD-10 codes are valid up to four and even five characters, there are codes that are valid up to three characters only e.g. I10. These codes cannot be rejected by medical schemes. This is referenced to the MIT as: Valid_ICD10_Primary and most recent definition namely: GSN0004. Please note that the dot (.) used in the ICD-10 codes preceding the 4th character is not regarded as a character. However, it must be reflected as part of the ICD-10 code for 4th and 5th character codes.

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 more specific information is not available, as a last resort, the ".99" unspecified characters can 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 healthcare 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 codes may even go to a 6 or 7 character levels 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.

Rule #	ICD-10 Claim Rule Description
CR0011	In the ICD-10 MIT, 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.

Example of **Primary** ICD-10 code up to **maximum level of specificity**:-

ICD-10 Code	ICD-10 Description	Maximum Specificity
M65.3	Trigger finger	NO
M65.34	Trigger finger, hand	YES
N63	Unspecified lump in breast	YES

Example of **Secondary** ICD-10 code up to **maximum level of specificity**:-

ICD-10 Code	ICD-10 Description	Maximum Specificity
W01	Fall on same level from slipping, tripping and stumbling	NO
W01.0	Fall on same level from slipping, tripping and stumbling, home	NO
W01.00	Fall on same level from slipping, tripping and stumbling, home while engaged in sports activity	YES

3.3.9 Complications

A complication usually arises subsequent to:

- an existing condition, disease, pregnancy, injury, etc.;
- treatments and procedures;
- adverse reactions to drugs and / or chemicals.

A complication may become a primary diagnosis despite it not being the initial reason for seeking medical treatment. Examples are specified in the *South African ICD-10 Morbidity Coding Standards and Guidelines* document.

3.3.10 Co-morbid Conditions

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

3.3.11 Maternity Codes

Codes O80-O84 (Delivery section in the WHO ICD-10 Volume 1 in chapter XV) should only be used for primary morbidity coding if no other condition classifiable to Chapter XV: *Pregnancy, childbirth and the puerperium* is recorded.

3.3.12 Morphology Codes (ICD-O)

The morphology code records the kind of tumour that has developed and how it behaves. This means that morphology codes will need to be supplied with all WHO ICD-10 Volume 1 Chapter 2 (Neoplasm) codes where surgery has been performed or where pathology / laboratory investigations have been done to confirm the underlying cell type of the neoplasm.

3.4 Combination Coding

There are certain diseases or conditions that require a set of two codes to correctly or accurately describe a particular disease or condition.

The following are the four most common examples of Combination Coding:

3.4.1 Sequelae Codes

You are referred to the latest version of the *South African ICD-10 Morbidity Coding Standards and Guidelines* document for the existing and most recent definition namely: GSN0015.

NOTE:

A sequela code can NEVER be used on its own or in the primary position.

Example 1: Dysphagia due to stroke.

Diagnosis	ICD-10 Code	ICD-10 Description
PDX	R13	Dysphagia
SDX	I69.4	Sequelae of stroke, not specified as haemorrhage or infarction

The primary diagnosis (PDX) is the late effect: *Dysphagia* and the secondary diagnosis (SDX) is the initial or sequelae condition: *Due to stroke*.

Example 2: The patient presents with osteonecrosis of the pelvic region due to a hip replacement performed 18 months ago after a fracture of the femur was sustained in a motor vehicle accident.

Diagnosis	ICD-10 Code	ICD-10 Description
PDX	M87.25	Osteonecrosis due to previous trauma, pelvic region and thigh
SDX	T93.1	Sequelae of fracture of femur
SDX	Y85.0	Sequelae of motor-vehicle accident
SDX	Z96.6	Presence of orthopaedic joint implants

The primary diagnosis (PDX) is the late effect: *Osteonecrosis due to previous trauma, pelvic region and thigh* and the secondary diagnosis (SDX) is the initial or sequelae condition: *Due to a fracture of femur sustained in a motor-vehicle accident*.

3.4.2 External Cause Codes (ECC)

ECC allow for the classification of environmental events, circumstances and conditions as the cause of injury, poisoning and other adverse effects.

The South African standard stipulates that all S and T codes must be accompanied by the ECC. ECC must always be used to the maximum level of specificity. Refer to the WHO ICD-10 Volume 1 Chapter XIX on Injury, poisoning and certain other consequences of external causes (S00 – T98).

ECC is found in the MIT and also in the WHO ICD-10 Volume 1 Chapter XX External causes of morbidity and mortality (V01 – Y98).

The primary diagnosis (PDX) is the injury or poisoning code and the ECC is the secondary diagnosis (SDX).An injury or poisoning code can also be used in secondary position, but it must still be followed by an ECC.

NOTE:
An ECC code can NEVER be used on its own or in the primary position.

For example: Open fracture neck of femur due to fall from tree, at home, whilst gardening. The patient has also been diagnosed with Cushing's syndrome as a result of cortisone therapy.

Diagnosis	ICD-10 Code	ICD-10 Description
PDX	S72.01	Open fracture neck of femur
SDX	W14.03	Fall from tree, at home, whilst engaged in other types of work
SDX	E24.2	Drug induced Cushing's syndrome
SDX	Y42.0	Glucorticoids and synthetic analogues

NOTE:
The ECC section requires coding to the maximum level of specificity.

3.4.3 Dagger (+) and Asterisk (*) Codes

Codes marked with a dagger (+) are considered the main or primary code indicating the underlying disease, while codes marked with an asterisk (*) are considered optional or secondary codes indicating the resulting manifestation.

- A dagger code (+) can be used on its own when there is no manifestation.
- In sequencing, an asterisk code (*) is always preceded by a dagger code.
- An asterisk code (*) can NEVER be used on its own or in the primary position.

NOTE:
Not all dagger codes are marked with the symbol (+) and any code, as appropriate, may become a dagger code. Medical schemes may not reject a claim for the reason that a code not marked as such was used as a dagger code together with an asterisk (*) code. All codes to be used for the resulting manifestation are marked with the symbol (*) to indicate that these are asterisks codes.

There are 83 special asterisk categories listed at the start of the relevant chapters in the WHO ICD-10 Volume 1 book.

For example: Tuberculous peritonitis

Diagnosis	ICD-10 Code	ICD-10 Description
PDX	A18.3+	Tuberculosis of intestines, peritoneum and mesenteric glands
SDX	K67.3*	Tuberculous peritonitis

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

3.4.4 Local Infections

Coding of some infections requires an additional code in order to identify the organism(s) that is causing the infection.

For example: Acute cystitis due to E.coli infection

Diagnosis	ICD-10 Code	ICD-10 Description
PDX	N30.0	Acute cystitis
SDX	B96.2	Escherichia [E.coli] as cause of diseases classified to other chapters

NOTE:
Causative Organism Codes can never be in the primary position (B95 – B98)
The code indicating the infection always precedes the code representing the infectious agent from the range B95 – B98.
The site of infection is coded as the primary diagnosis (PDX) and the infecting organism as the secondary diagnosis (SDX).

3.4.5 Sequencing of ICD-10 Codes

Determine whether the first code in the primary position on a claim is valid and complete.

NOTE:
A maximum of 10 (ten) ICD-10 codes in total must be allowed for per line item and / or referral diagnoses.

3.5 Clinical Validation Rules

3.5.1 General Rules

Rule #	ICD-10 Claim Rule Description
CR0012	ICD-10 codes must be included on all claims / accounts / statements regardless of whether the patient or medical scheme is the recipient and of any payment arrangement between any parties in the communication channel.
CR0013	Only a healthcare provider treating a specific patient / member can select and include an ICD-10 code(s) on a claim / account / statement. No patient or any other third party may do so.
CR0014	A healthcare provider should use the sign and symptom codes in ICD-10 until such time as he / she can confirm the diagnoses / condition.
CR0015	Inclusion of other diagnosis-related classifications Other ICD-10 related coding schemas do exist e.g. DSM-IV, ICD-DA, ICD-O and could be used as "plug-ins" to the ICD-10 MIT schema. Most of the plug-ins consist of the basic ICD-10 codes with extra characters (5th or 6th) for extra specificity. South Africa only accepted ICD-O as part of the published ICD-10 MIT.
CR0016	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 healthcare providers are not allowed. By allowing different sets of rules and conventions the entire process is undermined and the consistency in application is compromised. The *South African ICD-10 Morbidity Coding Standards and Guidelines* document is the agreed diagnostic coding standard accepted by all healthcare industry stakeholders as the coding standard of choice.

3.5.2 PMB Conditions

All members of medical schemes are guaranteed a minimum set of benefits called Prescribed Minimum Benefits (PMBs). The benefits now include a limited set of diagnostic treatment pairs, chronic conditions and emergency medical conditions. The only way to determine if an episode of care constitutes a Prescribed Minimum Benefit is through a diagnosis code assigned together with the related treatment.

Medical schemes, administrators and managed care organisations must be able to identify the PMB ICD-10 code, regardless of whether the PMB ICD-10 code is the PDX or SDX.

3.5.3 Different ICD-10 codes on Different Claims

Rule #	ICD-10 Claim Rule Description
CR0017	Healthcare providers cannot be penalised by medical schemes if their ICD-10 codes differ from that of other healthcare 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 ICD-10 Task Team. The ICD-10 Task Team's role is to assist in slotting in ICD-10 coding into current common practice, and not to interfere with prevailing clinical processes.

3.5.4 Pre-authorisation versus Claims

The following standard response was drafted by the ICD-10 Task Team 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."

Rule #	ICD-10 Claim Rule Description
CR0018	Members and healthcare providers may thus not be refused authorisation if no ICD-10 code but only a description of the condition is available.

3.5.5 ICD-10 codes not appropriate for patient age

Rule #	ICD-10 Claim Rule Description
CR0019	During phase 4 of the ICD-10 implementation plan, an 'Age' indicator has been included in the latest version of the ICD-10 MIT. This Age indicator must be used to determine when a specific ICD-10 code is clinically appropriate for use. This indicator has been compiled based on the WHO Volume 1 Tabular List.

3.5.6 ICD-10 codes not appropriate for patient gender

Rule #	ICD-10 Claim Rule Description
CR0020	During phase 4 of the ICD-10 implementation plan, a 'Gender' indicator has been included in the new version of the MIT. This Gender indicator must be used to determine when a specific ICD-10 code is clinically appropriate for use. This indicator has been compiled based on the WHO Volume 2 Instruction manual, chapter 3 and paragraph 3.1.5: Categories with common characteristics, limited to one sex.

3.4.7 Use of Morphology Codes (ICD-O)

A decision was taken to implement the morphology codes as published in ICD-O Version 3. The list forms part of the MIT.

Rule #	ICD-10 Claim Rule Description
CR0021	The indexing rules should be applied by clinical coders in assigning the codes according to the morphological description supplied.

4. ICD-10 code Rules for Claim Data Capturing and Submission

It is important to understand how to specify ICD-10 codes on claims and the rules around including ICD-10 codes on claims, whether on paper or electronic format.

The PHISC Messaging Standards sub-committee developed a technical specification that was adopted by the then National Task Team on ICD-10 Implementation and published by the CMS as the *PHISC Guidelines on Submission of ICD-10 Codes* dated August 2005.

This technical document's aim was to standardise the claiming process as well as to alleviate problems experienced in the submission of ICD-10 codes. The original document consisted of two parts:

Part 1: Including ICD-10 codes in claim data capture and submission
Part 2: Including ICD-10 codes in the MEDCLM / EDIFACT message format

Taking other pertinent documentation into consideration, the next section should be viewed as the most up-to-date document regarding technical claim capturing and submission requirements for ICD-10 codes.

4.1 General Rules

Rule #	ICD-10 Claim Rule Description
CR0023	Non-disclosure of a diagnosis by the member of a medical scheme or a healthcare provider (U98.- range) • Under such circumstances, the medical scheme is under no obligation to reimburse the member or the healthcare provider as a claim would still not entirely conform to the requirements of the legislation. Any attempt to do so would constitute non-compliance with prevailing legislation.
CR0024	If a provider makes a diagnosis, he/she will need to supply ICD-10 code(s), even on pre-paid accounts / claims / invoices in order to allow the medical scheme member to submit claims that are compliant with legislation, to the medical scheme. The requirement to submit ICD-10 codes 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.

4.2 Role of Software / PMA and Switching Companies

One of the important stakeholders in the implementation of ICD-10 has been software houses (also referred to as Practice Management Application (PMA) vendors) and switching companies who manage and process patient information from healthcare providers to medical schemes on a daily basis. The participation of these stakeholders helped in the development of appropriate paper and electronic standards for the transmission of ICD-10 codes.

PMA software vendors are expected to comply with the following guidelines and rules:-

Rule #	ICD-10 Claim Rule Description
CR0025	PMA software systems must provide the functionality to capture ICD-10 codes, which is the domain of the PMA.
CR0026	The latest version of the electronic ICD-10 Master Industry Table (MIT) must be used.
CR0027	Always code up to the highest level of specificity, 3rd, 4th and 5th characters, as appropriate.
CR0028	The user must be able to alter previously selected ICD-10 codes, when required. A user should be able to edit and override ICD-10 codes on an item level, where the software has allocated ICD-10 codes automatically from a claim level down to all items in the claim.
CR0029	Dagger/asterisk symbols must be displayed within electronic look-up lists.
CR0030	Electronic look-up lists are preferred over the manual typing of ICD-10 codes.
CR0031	Allow a maximum of ten (10) ICD-10 codes per line item for healthcare providers and/or referral diagnosis, i.e. 1 primary ICD-10 code and 9 secondary ICD-10 codes.
CR0032	Allow a maximum of thirty (30) ICD-10 codes per healthcare facility claims, i.e. 1 primary ICD-10 code and 29 secondary ICD-10 codes.
CR0033	Electronic and paper claims: Omit dagger/asterisk symbols.
CR0034	Paper and electronic claims: **NO** diagnostic descriptions may appear on claims.
CR0035	No ICD-10 codes for modifiers (except for modifier 0017 for medical practitioners). 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(s) for the modifier will be assumed to be the same as that for the main preceding procedural code. In the case of modifier 0017 this code is used as a stand-alone code and does not have to be preceded by another code, therefore an ICD-10 code(s) should be added to this modifier line.
CR0036	Dental Laboratories and Dental Technician Claims In the past, dental practitioners submitted all dental laboratory claims to medical schemes and patients as part of their own claims. From 1 February 2008, legislation enables registered dental technicians to submit their claims directly to patients and schemes. Implementation was largely delayed to accommodate logistical arrangement by technicians, dentists and medical schemes. With the advent of the new legislation, all dental technicians – irrespective of whether or not they choose to submit claims directly to medical schemes – are now required to include ICD-10 codes on their claims, which must conform to the line item requirement (the mandatory submission of ICD-10 codes at a line level). Dental technicians are non-diagnosing practitioners and therefore unable to determine which ICD-10 diagnostic code(s) to use. Please refer to the *South African South African ICD-10 Morbidity Coding Standards and Guidelines* document for information regarding the appropriate default codes to be added to each line on their claims. The referring dentist should supply a referral diagnosis code which should be placed in the designated space for referral diagnosis within a claim. This will allow schemes to determine if the services rendered refer to a PMB condition and thus ensure that the correct benefits are allocated for the services rendered. (Refer to Circular 26 of 2008: *ICD-10 coding for dental laboratory and technician claims*) and Circular 29 of 2010: Clarification of ICD-10 coding for dental laboratory and technician claims).

Rule #	ICD-10 Claim Rule Description
CR0037	The primary code is always the first code followed by the secondary / other codes. Third parties i.e. switching companies or pharmaceutical benefit management (PBM) 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 and / or translation of data.
CR0038	Electronic claims' submission formats typically dictate the separator to be used between multiple codes: • Proprietary Comma-delimited formats: Use a forward slash (/) without any additional separators like spaces between ICD-10 codes. • PHISC MEDCLM / EDIFACT format: Use a forward slash (/) without any additional separators like spaces between ICD-10 codes. • PHISC and / or Proprietary XML formats: Different tags will be used for multiple ICD-10 codes.
CR0039	Paper claims: Delimited with a space, a forward slash (/) and another space.
CR0040	It is the responsibility of the healthcare provider to ensure that they are completely familiar with how ICD-10 coding is handled within their PMA software systems.
CR0041	ICD-10 code printed on line below procedural code line item If the ICD-10 code cannot be accommodated on the same line, then it will be recognised as a roll-over if it is on the line directly below the description of the services rendered.

4.3 PHISC Technical Document Part 1: Including ICD-10 Codes in Claim Data Capture and Submission

This covers the process from the initial capturing of claim data by a service provider up to the point where a claim is processed by a medical scheme or administrator. It is aimed at service providers, software vendors and third parties like switches.

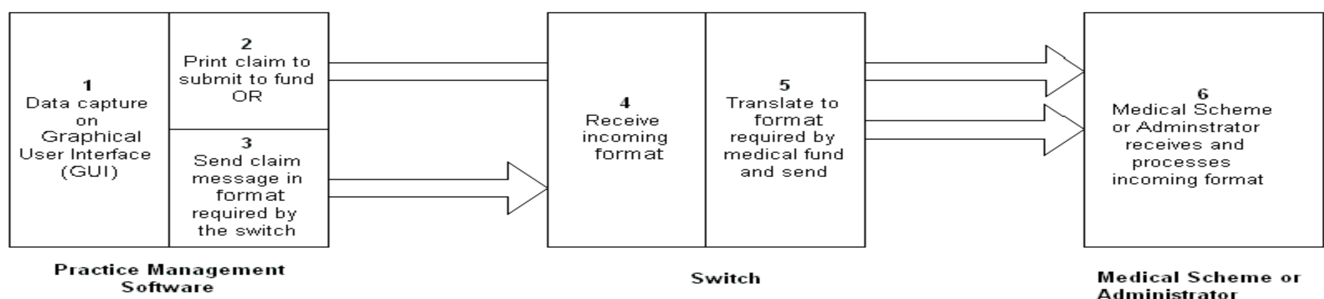
It gives a technical overview of the claims transmission process. Common errors are also addressed and some requirements are specified to ensure that ICD-10 codes are submitted correctly at the source and transmitted correctly.

Each practice management software program vendor has implemented the way that ICD-10 codes must be typed or selected in a different way. It is the healthcare provider's responsibility to familiarise themselves with the specific way in which their program works. It falls outside the scope of the Task Team to dictate implementation and/or work processes within these practice management software programs.

It is the responsibility of the practice management software program vendor to ensure that when claims are generated, on paper or electronic, that the ICD-10 codes are presented in the prescribed format.

4.3.1 Including ICD-10 codes in claim data capturing and submission

The claim submission process flow can be described according to 6 main points:



4.3.2 Data capturing on Practice Management software

There has been some confusion in the use of the term *line items*, so this document will make use of the term *item* and *item level* where claimable items are concerned. Depending on the format used, items in a claim may have more than one physical line, but the number of lines is not relevant.

The PMA software should enable the practitioner to:

- Submit *referring* ICD-10 diagnoses codes on a *header* or claim level (excluding hospitals).
- Submit *treating* ICD-10 diagnoses codes on an *item* level (on a header level by hospitals).

The functionality of the PMA software in capturing ICD-10 codes is largely the domain of the software designer. No comprehensive standard has been set in this regard, except that the captured data should enable the proper handling of ICD-10 codes in the electronic claim.

The software design MUST ENSURE that all the user has to do, is choose a code, or in the very worst case, type a code into a field. There should be no need for a user to have to interpret anything further, or to add anything further.

Where manual typing of codes occur, users and software vendors should take note of the following common errors as received by medical schemes or administrators. The use of a forward slash (/) as a delimiter in the examples given below is for the benefit of software vendors who have to program correctly to transmit the ICD-10 codes electronically and *does not apply to how users should enter codes*:

- 3-character codes

  T14. Dot incorrect
  T14 □ Space incorrect
  T14. □ Space and dot incorrect

  The correct submission is: T14

  When a code is carried to the medical scheme 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 could encounter a problem because it expects another character and in this case there is no character or a space.

- Multiple 3-character codes

  T14 □/T15□/T16 Spaces follow each code before the "/" this is incorrect)
  T14. □/T15.□/T16. Dots and spaces follow each code - this is incorrect)

  The correct submission is: T14/T15/T16

  When an electronic claim is created and submitted, the software program should automatically send the above example as G64/G92/G98 (No dots and no spaces within this string of codes).

  Electronic switching or transacting simply transforms what was specified into a data field into the correct electronic message format. This message is then received by the medical scheme. 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.

  Healthcare providers have to familiarise themselves with the exact way in which the software program requires the operator (i.e. 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.

- Extended code to maximum specificity

  The aim is for all providers to submit valid ICD-10 codes, coded to the maximum level of specificity.

- Use only correct characters

  JO9.1 - Incorrect use of capital O instead of a zero 0
  J01.l - Incorrect use of lower case “L” or upper case “I” instead of a one (1)
  086.1 - Incorrect use of zero (0) instead of the upper case O

4.3.3 Printing paper claims from PMA software

The problems experienced by funders regarding paper claims at the moment, necessitates this section.

The general rule, which also applies to paper claims, is that ICD-10 codes must be supplied on item level. This means that ICD-10 codes must be supplied on tariff level for all procedures and NAPPI level for all medicines. Modifiers and dental technician laboratory items are excluded.

The following example of a paper claim shows the ***incorrect*** submission of an ICD-10 code only on the consultation item and not the medicine header line or on NAPPI items:

*** SCALE OF BENEFITS *** Referred by : 723-5634

Ref#	Date	Patient	#	D.O.B	Tariff	Author	NAPPI / ICD Code	Description	Qty	Amount	Payment	Outstand	Rup Total
182740	9/07/2005	Patien Name		28/10/1978	0182		L02.9/J20.9	Acute bronchitis, unspecific	1	170.00		170.00	170.00
182741	9/07/2005				0201		778249011	3ML VOLTAREN INJECTION	1	10.17		10.17	180.17
182742	9/07/2005				0255			DRAINAGE OF SUB. ABSCESS	1	121.20		121.20	301.37
182743	9/07/2005						829102019	100ML ADCO-AMOXYCILLIN 250MG	1	24.00		24.00	325.37
182744	9/07/2005						873551001	2G ACITOP CREAM	1	18.03		18.03	343.40
182745	9/07/2005						797553002	20 500MG APEN CAPS	1	24.50		24.50	367.90
								*** Medicine 66.53					

EDI : DISC Submitted on : 9/07/2005 - Batch # : 15011

*** THIS ACCOUNT IS INCLUSIVE OF VAT ******

TOTAL DUE 367.90

The result will be that a medical scheme or administrator will only apply the ICD-10 code to tariff 0182 and not to any of the lines following it.

It is a legislative requirement for all claims submitted to medical schemes by either the health care service provider or members of medical schemes should include an ICD-10 code or codes. Circular 19 of 2007 aimed to clarify the submissions of paper claims highlighting the issues with **how** ICD-10 codes are submitted i.e. the correct format of codes. It has been identified that clarification is needed on **where** on a claim the ICD-10 code information should be presented.

Any claim submitted to a medical funder for reimbursement purposes must at least cater for:-

(1) a **single** billing practice with
(2) a **single** treating / attending service provider for a
(3) **single** patient on a
(4) **single** date of service.

BUT could also cater for:-

(1) a **single** billing practice with
(2) **multiple** treating / attending service providers for a
(3) **single** patient on
(4) **multiple** dates of service.

Practice Management Applications (PMAs) are currently not regulated by any legislative body and subsequently the mandatory criteria to be printed / presented on a claim (as set out in the Medical Schemes Act 131 of 1998) does not specify exactly where on a claim the information needs to be presented.

This means that PMA vendors interpret and implement the legislative requirements as they see fit. Because of this gap in controlling the information presented on a Claim, medical schemes have to cater for all and any formats presented to them for reimbursement. No rejections can currently be enforced on the premise that information is presented incorrectly.

The information required per line item can be reduced and its intention or context can become clearer by identifying common pieces of information that is applicable to the entire claim OR applicable to a portion of a claim, and then summarising it in a clearly marked area of the claim.

Identifying common pieces of information on a claim:

1. Common pieces of information applicable to an entire Claim:
   - Date and account number information
   - Supplier or billing practice information
   - Medical scheme information including member information
   - Claim and / or invoice number information
   - Patient information
   - Claim or billing event financial information

2. Common pieces of information applicable to specific portion(s) of a Claim:
   - Treating provider information
   - Referral and / or prescriber information

3. Pieces of information that is NOT common, and cannot be summarised:
   - Detailed treatment information
   - Additional information required for dental claims, pathology claims, optometric claims and COID claims
   - Additional information for dispensed items and / or for pharmaceutical products used during treatment
   - Item's Diagnosis information
   - Item's Financial information

Some people and / or organisations could refer to the above sections as levels of a claim, or headers and sub-headers, but we encourage everyone to refer to these sections as **summaries** (described in point 1.1 and 1.2) **and line detail** (described in point 1.3) because 'headers' typically refer to an electronic file layout / specification and therefore excludes paper representations.

For example:
A single billing practice consists of three (3) service providers treating patients and / or performing medical services. A specific patient was treated on day 1 by service provider 1 on request of the patient's family practitioner (service provider 0). On day 2, the patient is treated by service provider 2 on request of service provider 1.

4. System A does not cater for multiple service dates per patient per Claim OR System A's internal business rule is to generate a claim per treating provider, per patient, per service date. This means that the system will ALWAYS only include one set of information for the treating service provider and one set of information for the referring provider that includes the referring diagnoses.

Claim

XYZ MEDICAL SPECIALIST PRACTICE AND ASSOCIATES

Page: 01/01

PCNS Number : 016 000 1111111
VAT Number : 1234567/8
Telephone : + 27 012 6531122

Address : ROOM 10 WIERDA HOSPITAL
: 777 TOWN STREET
: WIERDA PARK 0149

MR GEORGE GREEN
10 TOWNHOUSE COMPLEX
155 CHURCH STREET
WIERDA PARK
CENTURION
0149

Account Number : GREEN001
Date Created : 20080601

Medical Scheme Name: ABC MEDICAL SCHEME

Option / Plan Reference : OPT001
Membership Number : 0123456789

Member ID Number : 500101 0101 01 1
Member VAT Number :
Telephone : +27 012 6532211

Elec. Response Required : N

Claim Number : 100000001255
Values are VAT inclusive @ 14% and are claimed in South African Rand

Claim Totals	Collection	VAT	Gross	Discount	Claimed
	9999999.99	9999999.99	9999999.99	9999999.99	9999999.99

Patient Name : ANNIE ANDERSON, AA
Patient Identification : ID No.: 4801010109089 Code: 01 Date of Birth: 19480101 Gender: F

Treating / Attending Provider
DR SIMON SPECIALISTO
PCNS Number : 016 000 2222222
HPCSA Council Number : MP111111

Referring Provider
DR GERARD GENERAL
PCNS Number : 014 000 8888888
HPCSA Council Number : MP22222

Ref. Provider Diagnosis : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99

Itm	Service Date	Proc.code	Description	Qty	Patient	Gross	Discount	Claimed
001	[illegible]	0190	New & established pat	1	0.00	172.60	0.00	172.60

Diagnoses : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99

Referring Service Provider Diagnoses

Treating Service Provider Diagnoses

Section 1.1

Section 1.2

Section 1.3

5. System B caters for multiple service dates per patient per Claim. This means that when a Claim is generated, multiple sets of information for the multiple treating service providers and their linked referring information (where applicable) must be catered for.

Claim

XYZ MEDICAL SPECIALIST PRACTICE AND ASSOCIATES

Page: 01/01

PCNS Number : 016 000 1111111
VAT Number : 1234567/9
Telephone : + 27 012 6531122

Address : ROOM 10 WIERDA HOSPITAL
: 777 TOWN STREET
: WIERDA PARK 0149

MR GEORGE GREEN
10 TOWNHOUSE COMPLEX
155 CHURCH STREET
WIERDA PARK
CENTURION
0149

Account Number : GREEN001
Date Created : 20080601

Medical Scheme Name: ABC MEDICAL SCHEME

Option / Plan Reference : OPT001
Membership Number : 0123456789

Member ID Number : 500101 0101 01 1
Member VAT Number :
Telephone : +27 012 6532211

Elec. Response Required : N

Claim Number : 100000001255
Values are VAT inclusive @ 14% and are claimed in South African Rand

Claim Totals	Collection	VAT	Gross	Discount	Claimed
	9999999.99	9999999.99	9999999.99	9999999.99	9999999.99

Section 1.1

Patient Name : ANNIE ANDERSON, AA
Patient Identification : ID No.: 4801010109089 Code: 01 Date of Birth: 19480101 Gender: F

Treating / Attending Provider
DR SIMON SPECIALISTO
PCNS Number : 016 000 2222222
HPCSA Council Number : MP111111
Ref. Provider Diagnosis : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99

Referring Provider
DR GERARD GENERAL
PCNS Number : 014 000 8888888
HPCSA Council Number : MP22222

Section 1.2

Itm	Service Date	Proc.code	Description	Qty	Patient	Gross	Discount	Claimed
001	20080601 08:00	0190	New & established pat	1	0.00	172.60	0.00	172.60

Diagnoses : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99

Section 1.3

Treating / Attending Provider
DR PETER PHYSICIAN
PCNS Number : 016 000 3333333
HPCSA Council Number : MP33333
Ref. Provider Diagnosis : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99

Referring Provider
DR SIMON SPECIALISTO
PCNS Number : 016 000 2222222
HPCSA Council Number : MP111111

Section 1.2

Itm	Service Date	Proc.code	Description	Qty	Patient	Gross	Discount	Claimed
001	20080610 08:00	0190	New & established pat	1	0.00	172.60	0.00	172.60

Diagnoses : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99

Section 1.3

It is the service provider's responsibility to ensure that you select the correct and appropriate ICD-10 codes to describe all patient encounters. When you submit claims through to medical schemes or administrators for reimbursement purposes you have to ensure that the practice management application (PMA) and / or electronic switching company that you are contracted with, adheres to these claim submission guidelines. If you are unsure about your PMA's accuracy or capability, or if you have received messages regarding incorrect codes on your medical scheme reconciliation statements, please contact your PMA vendor directly. If you are not using commercially available software, please ensure that your program has the required capability to guarantee correct coding submissions.

4.3.4 Submitting electronic claims from PMA software

If an electronic claim submission process is followed, the ICD-10 codes captured by the PMA software, is included in the electronic claim. The captured data should enable the creation of a claims message by the software back-end that adheres to the rules for electronic claims transmission set out in appendix A. The rules in appendix A pertain specifically to electronic claim messages in any format and *not* in all cases to data capturing or printed claims.

The following example illustrates this:

> Software may use a pipe (|) or semicolon (;) or any other character as a delimiter when capturing the codes and concatenating or stringing together ICD-10 codes per item. However, when the electronic claim is sent, *only* a forward slash (/) may be used as a delimiter between concatenated ICD-10 codes (there is a rule that caters for the forward slash in morphology codes – appendix A point 4.1).

Note that *descriptions* of diagnosis codes may not be transmitted electronically or printed on any claim. Only the ICD-10 codes should be included. This is for reasons of privacy and confidentiality.

4.3.5 Receipt of electronic claims by third parties

Electronic claims are often sent to switches and other companies like pharmaceutical benefit companies, who add value to the process by validating data, etc. This requires that the service provider sends claims in the format required by the third party.

The rules in appendix A have been designed as general rules that can be applied to all of any electronic formats. It may be that some of the formats have inherent limitations when the rules are applied. It looks as if these cases are the exception, but if a format cannot handle the ICD-10 requirements, a solution should be negotiated by the partners involved, to enable the correct transmission of ICD-10 codes.

4.3.6 Translation of claims and sending to medical schemes or administrators by third parties

Third parties, such as switches, often find it necessary to translate claims received in one format into another format. This is mainly due to the specific formats required by the medical schemes, administrators or other parties.

Care should be taken by switches and other third parties to maintain the integrity of the ICD-10 codes in the original format. This includes the correct transmission of referring and treating diagnoses and the sequence of diagnosis codes. For example where a format cannot flag / indicate primary and secondary ICD-10 codes, the sequence of ICD-10 codes on an item level should be maintained to denote the primary code (always the first code in the list of codes for the item) and the secondary codes.

4.3.7 Receipt of electronic claims by medical schemes or administrators

This is the last step of the process as far as ICD-10 codes are concerned. The medical scheme or administrator processes the received claim according to the ICD-10 information included and this can lead to the rejection of a claim if no ICD-10 codes were supplied, or if the ICD-10 codes are technically or diagnostically incorrect. It may also mean that a claim will be paid from the wrong benefit or risk pool, to the detriment of the patient. To ensure that ICD-10 codes are supplied correctly and validated uniformly, the standard ICD-10 MIT industry code list must be used by all parties concerned.

4.4 PHISC Technical Document Part 2: Including ICD-10 Codes the PHISC MEDCLM / EDIFACT Message

The second part of the document is aimed at medical schemes and administrators, their IT departments and other parties who send and accept claims in PHISC MEDCLM / EDIFACT. This electronic file format is the de facto national standard developed by PHISC.

It is the intent of this part of the document to set a standard for ICD-10 code transmission, specifically where the PHISC MEDCLM / EDIFACT message is used as a claim submission format between business partners, in private or public sector.

UN/EDIFACT is an international messaging standard owned by the United Nations. It was adopted as a national standard by PHISC. As such, it is used by a significant part of the South African healthcare industry.

The UN/EDIFACT specification contains different messages for different purposes, each denoted by a message identifier. The messages in the UN standard that come closest to our medical claims are the MEDRUC (version D04A) and lately the IHCEBI (version D04B) messages. Because the South African healthcare industry had specific requirements that differed substantially from the above messages, we have constructed our own MEDCLM message when EDIFACT was first adopted. This means that the MEDCLM message is uniquely South African.

4.4.1 The structure of the MEDCLM message

4.4.1.1 Message Groups

The PHISC MEDCLM / EDIFACT standard defines the different message groups as follows:

Group 0: Message header and trailer segments

Group 1: A group of segments applicable to the entire claim, which is used to carry information for payment decisions. This includes the principal member and billing provider details.

Group 2: A group of segments that provides patient encounter details. This group includes group 3 and 4.

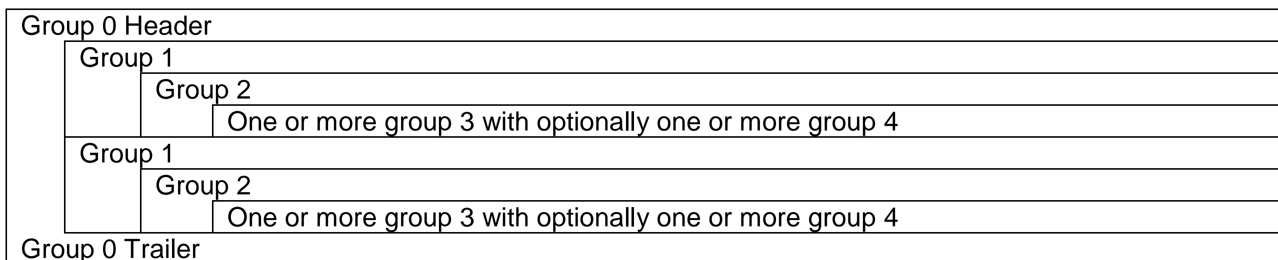
Group 3: A group of segments used to identify tariffs, modifiers, monetary amounts, discounts and rates per item. It can include one or more group 4's.

Group 4: Optionally a group of segments used to identify medicines and other medical consumables used. It is nested within a group 3 and links directly to a specific procedure code submitted in Group 3.

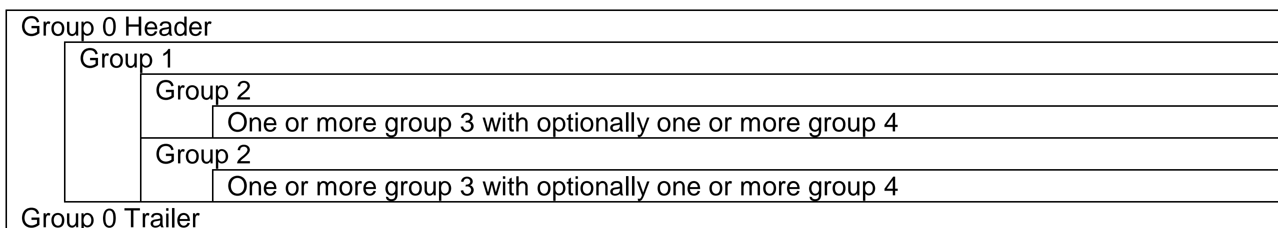
4.4.1.2 Variants of the MEDCLM structure

Different structures of a MEDCLM claim regarding the use of *Group 1 and 2* are currently in use in the industry, for example:

- One Group 1 with one Group 2

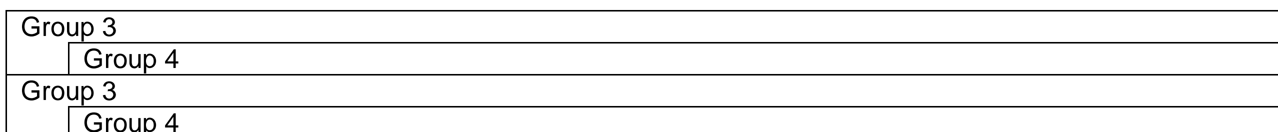


- One Group 1 with multiple Group 2s

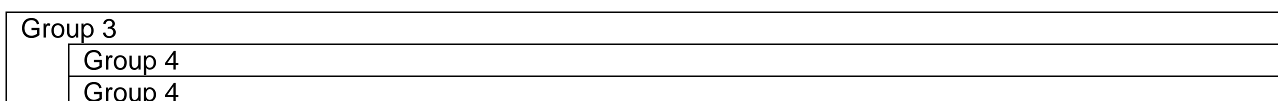


Within the two above permutations there are also variant structures as far as the use of G*roup 3 and 4* is concerned:

- One Group 3 with one Group 4



- One Group 3 with multiple Group 4s



4.4.1.3 PHISC MEDCLM / EDIFACT message and ICD-10 code segments

Against this background all the rules for the electronic submission of claims in appendix A must be applied to the PHISC MEDCLM / EDIFACT message.

The PHISC MEDCLM / EDIFACT standard allows for ICD-10 codes in so-called RFF+ICD segments. The RFF+ICD segments may be used on Group 1, 3 and 4. The code component of the segment allows for codes to be concatenated (strung together) up to *35 characters* long:

Group	Diagnosis segment	*Allowed*
Group 1	RFF+ICD:code/code/code/code'	Up to two segments with codes up to 35 characters per segment. The *referring* practitioner diagnosis goes here.
Group 2	Not allowed	Not allowed
Group 3	RFF+ICD:code/code/code/code'	Up to two segments with codes up to 35 characters per segment. For procedures, the *treating* practitioner diagnosis goes here.
Group 4	RFF+ICD:code/code/code/code'	Only one segment with codes up to 35 chars per segment. For medicines or consumables, the *treating* practitioner diagnosis goes here.

4.4.1.4 Examples of the correct submission of ICD-10 codes in the PHISC MEDCLM / EDIFACT message

EXAMPLE 1 - Correct submission of a claim with one Group 4 per Group 3 (ICD-10 supplied only on Group 3)

If a claim contains a Group 3 with an ICD-10 code and the Group 3 contains a single Group 4 with a NAPPI code then it could be safely assumed that the ICD-10 code submitted on the group 3 applies to the Group 4 item.

Group 0	BGM+++97:20040909:102++BAT:000000000000017500'
Group 1	NAD+SUP+1400000++Dr PIET' NAD+MSN+123456789' NAD+MN+++BADAT' NAD+MIN+++AHMED' NAD+MPN+41807' NAD+TDN+1445678++Dr KOOS' RFF+PRE:00006621' **RFF+ICD:I15.9"--------------------------------Referring Doctors diagnosis** RFF+ADE:C426'
Group 2	PAT+38+++++217:767' DTM+286:20040909:102' RFF+PTN:SUHAIL+285:19891226:102' RFF+PIN:SUHAI' RFF+DPN:002' RFF+PSU:BADAT' RFF+SX:M' RFF+RLN:Other'
Group 3	LIN+1+1++5:0181+++CAL:12070+100:UNT' RFF+IV:00006621' RFF+AE:51067250837562' RFF+CAF:0' RFF+PRO:0181' **RFF+ICD:T14' ----------------------Treating doctors diagnosis** FTX+PRO+++"Visit for a new problem/new patient with problem focused history, exa' UNS+C'
Group 3	LIN+1+2++5:0201+++CAL:2302+100:UNT'

	RFF+IV:00006621' RFF+AE:51067250837562' RFF+CAF:0' RFF+PRO:0201' **RFF+ICD:T14' ----------------------Treating doctors diagnosis** FTX+ITM+++0671452 Tray dressing-ofs dt22212c1' FTX+PRO+++"Cost of material and medicines used in treatment?: This item provides' UNS+C'
Group 4	RFF+CAF:0' RFF+PRE:00006621' RFF+TN:0000001' **RFF+DRG:671452002'-----------------This is a NAPPI code** FTX+MED+++Tray dressing-ofs dt22212c1' QTY+48:100' MOA+24+38:2302'
Group 3	LIN+1+3++5:0201+++CAL:3889+100:UNT' RFF+IV:00006621' RFF+AE:51067250837562' RFF+CAF:0' RFF+PRO:0201' **RFF+ICD:T14' ----------------------Treating doctors diagnosis** FTX+ITM+++0432067 E/crepe grade 1 0501 50mmx4,m' FTX+PRO+++"Cost of material and medicines used in treatment?: This item provides' UNS+C'
Group 4	RFF+CAF:0' RFF+PRE:00006621' RFF+TN:0000002' **RFF+DRG:432067027' ------------This is a NAPPI code** FTX+MED+++E/crepe grade 1 0501 50mmx4,m' QTY+48:100' MOA+24+38:3889'
Group 0	CNT+22:300' CNT+24:200' CNT+25:18261' CNT+27:6191' UNT+66+00006621'

EXAMPLE 2 - Correct submission of a claim with one Group 4 per Group 3 (ICD-10 supplied on Group 3 and 4)

If the claim has a Group 3 that contains a single Group 4 with a NAPPI item, then the ICD-10 code submitted on Group 4 always has a higher priority than the ICD-10 code submitted on Group 3 (if any).

Group 0	BGM+++97:20040909:102++BAT:000000000000017500'
Group 1	NAD+SUP+1400000++Dr PIET' NAD+MSN+123456789' NAD+MN+++BADAT' NAD+MIN+++AHMED' NAD+MPN+41807' NAD+TDN+1445678++Dr KOOS' RFF+PRE:00006621' **RFF+ICD:I15.9''-------------------------------Referring Doctors diagnosis** RFF+ADE:C426'
Group 2	PAT+38+++++217:767' DTM+286:20040909:102' RFF+PTN:SUHAIL+285:19891226:102' RFF+PIN:SUHAI' RFF+DPN:002' RFF+PSU:BADAT' RFF+SX:M' RFF+RLN:Other'
Group 3	LIN+1+1++5:0181+++CAL:12070+100:UNT' RFF+IV:00006621' RFF+AE:51067250837562' RFF+CAF:0' RFF+PRO:0181' **RFF+ICD:T14' ---------------------Treating doctors diagnosis** FTX+PRO+++"Visit for a new problem/new patient with problem focused history, exa' UNS+C'
Group 3	LIN+1+2++5:0201+++CAL:2302+100:UNT' RFF+IV:00006621' RFF+AE:51067250837562' RFF+CAF:0' RFF+PRO:0201' **RFF+ICD:T14' ---------------------Treating doctors diagnosis** FTX+ITM+++0671452 Tray dressing-ofs dt22212c1' FTX+PRO+++"Cost of material and medicines used in treatment?: This item provides' UNS+C'
Group 4	RFF+CAF:0' RFF+PRE:00006621' RFF+TN:0000001' RFF+DRG:671452002' **RFF+ICD:T14' ---------------------Treating doctors diagnosis on NAPPI** FTX+MED+++Tray dressing-ofs dt22212c1' QTY+48:100' MOA+24+38:2302'
Group 3	LIN+1+3++5:0201+++CAL:3889+100:UNT' RFF+IV:00006621' RFF+AE:51067250837562' RFF+CAF:0' RFF+PRO:0201' **RFF+ICD:T14' ---------------------Treating doctors diagnosis on NAPPI** FTX+ITM+++0432067 E/crepe grade 1 0501 50mmx4,m' FTX+PRO+++"Cost of material and medicines used in treatment?: This item provides' UNS+C'

Group 4	RFF+CAF:0' RFF+PRE:00006621' RFF+TN:0000002' RFF+DRG:432067027' **RFF+ICD:T14' ----------------------Treating doctors diagnosis on NAPPI** FTX+MED+++E/crepe grade 1 0501 50mmx4,m' QTY+48:100' MOA+24+38:3889'
Group 0	CNT+22:300' CNT+24:200' CNT+25:18261' CNT+27:6191' UNT+66+00006621'

EXAMPLE 3 - Correct submission of a claim with multiple Group 4's per Group 3

If the claim contains a Group 3 with an ICD-10 code and the group includes multiple Group 4's, then ICD-10 codes must be submitted on the Group 4 level. A medical scheme or administrator may not assume that the ICD-10 codes submitted on Group 3 apply to all the NAPPI items on Group 4. The ICD-10 code submitted on Group 4 always has a higher priority than the ICD-10 code submitted on Group 3 (if any).

Group 0	BGM++106+97:20050711:102++BAT:0000004717'
Group1	NAD+MIN+++S' NAD+MN+++KLOPPER' NAD+MPN+41807++DISCOVERY' NAD+MSN+123456789' NAD+SUP+1412345++DR KOOS' RFF+ADE:KLO002' **RFF+ICD:J11.1' ----------------Referring Doc's diagnosis** RFF+ACD:KLO002'
Group 2	DTM+286:20050615:102' RFF+DPN:2' RFF+PIN:M' RFF+PTN:MARILEE+285:19920116:102' RFF+SX:F' RFF+RLN:CHILD'
Group 3	LIN+1+1++5:0181+++CAL:17000+100:UNT' **RFF+ICD:J11.1'---------------Treating Doctors diagnosis** RFF+TR:4717114541' RFF+IV:11454+286:20050615:102' FTX+ITM+++CONSULTATION' UNS+C'
Group 3	LIN+1+2++5:0201+++CAL:600+100:UNT' **RFF+ICD:J11.1'---------------Treating Doctors diagnosis** RFF+TR:4717114597' RFF+IV:11459+286:20050615:102' FTX+ITM+++CONSUMABLES' UNS+C'
Group 4	RFF+CAF:0' RFF+DRG:701114002' **RFF+ICD:J11.1'---------------Treating Doctors diagnosis per NAPPI code** RFF+RFL:N' RFF+TN:000010200155' RFF+TR:4717114557' FTX+MED+++ADCO-DICLOFENAC 75MG 3ML INJ' QTY+48:100' MOA+24+38:259'
Group 4	RFF+CAF:0'

	RFF+DRG:549728007' **RFF+ICD:J11.1'---------------Treating Doctors diagnosis per NAPPI code** RFF+RFL:N' RFF+TN:000010200265' RFF+TR:4717114568' FTX+MED+++WEBCOL SWAB LARGE 15033' QTY+48:100' MOA+24+38:51'
Group 4	RFF+CAF:0' RFF+DRG:568056003' **RFF+ICD:J11.1'---------------Treating Doctors diagnosis per NAPPI code** RFF+RFL:N' RFF+TN:000010200375' RFF+TR:4717114579' FTX+MED+++SYRINGE DISP STERILE 3ML' QTY+48:300' MOA+24+38:168'
Group 4	RFF+CAF:0' RFF+DRG:468359004' **RFF+ICD:J11.1'---------------Treating Doctors diagnosis per NAPPI code** RFF+RFL:N' RFF+TN:000010200485' RFF+TR:47171145810' FTX+MED+++NEEDLE MICROLANCE 21G 1 GREEN' QTY+48:100' MOA+24+38:97'
Group 4	RFF+CAF:0' RFF+DRG:416726006' **RFF+ICD:J11.1'---------------Treating Doctors diagnosis per NAPPI code** RFF+RFL:N' RFF+TN:000010200595' RFF+TR:47171145911' FTX+MED+++COTTON WOOL 500G BALL' QTY+48:100' MOA+24+38:25'
Group 0	CNT+22:200' CNT+25:17600' CNT+24:500' CNT+27:600' UNT+72+106'

4.4.1.5 Multiple ICD-10 codes per line

Codes may be strung together up to 35 characters long. If a provider submits a number of ICD-10 codes and it exceeds the limit of 35 characters, then a second RFF+ICD tag may be created within a Group 3 only. For example:

Group 3	LIN+1+3++5:0201+++CAL:3889+100:UNT' RFF+IV:00006621' RFF+AE:51067250837562' RFF+CAF:0' RFF+PRO:0201' **RFF+ICD:Code1/Code2/Code3/Code4/Code5' ----------------Treating doctors diagnosis** **RFF+ICD:Code6/Code7/Code8/Code9/Code10' --------------Treating doctors diagnosis** FTX+ITM+++0432067 E/crepe grade 1 0501 50mmx4,m' FTX+PRO+++"Cost of material and medicines used in treatment?: This item provides'

4.4.1.6 Position of the Primary Code

The primary code is always the first code in the RFF+ICD code component. Where there are multiple RFF+ICD segments, the primary code is the first code in the *first* RFF+ICD segment. In the above example, **Code1** is the *primary code.*

4.4.2 PHISC MEDCLM / EDIFACT Appendix A: Rules for the electronic submission of ICD-10 codes

The following rules for the electronic submission of ICD-10 codes were agreed upon by PHISC and adopted by the National Task Team on ICD-10 implementation:

#	ICD-10 Electronic Claim Submission Rules
1.	The maximum expected length per code is 10 characters.
2.	ICD-10 codes must be supplied on item level. This means that ICD-10 codes must be supplied on tariff level for all procedures and NAPPI level for all medicines. Modifiers and lab slip items are excluded.
3.	In electronic transmission formats catering for header and item level: 3.1 Header: optional (mandatory for hospitals) for referring practitioner diagnoses. 3.2 Item: mandatory (not required for hospitals) for diagnosing practitioner diagnoses.
4.	Codes packed in one field are delimited with a forward slash (/). • For morphology codes, where a forward slash (/) is part of the code, the following rule applies: A forward slash followed by a numeric digit is not a delimiter, but is part of the code.
5.	In the non-hospital environment, provision must be made for 1 primary ICD-10 code plus up to 9 secondary ICD-10 codes. For hospitals, provision must be made for 1 primary plus up to 29 secondary codes. This is a specific South African standard.
6.	The primary code is always first, followed by the secondary codes.
7.	Daggers (†) and asterisks (*) are omitted in electronic transmission of ICD-10 codes. PMA software systems still need to work with daggers and asterisks to enable users to code clinically correct.
8.	An upper- or lowercase x is used as a placeholder for the 4th digit where a code does not have a 4th digit, but does have a valid 5th digit.
9.	The dot, which is an integral part of an ICD-10 code, is retained in electronic transmission.
10.	Descriptions of diagnosis codes may not be transmitted (or printed). Only the ICD-10 codes itself should be transmitted. This is for reasons of privacy and confidentiality.
11.	The ICD-10 industry list obtainable from BHF should be used to ascertain the validity of primary, secondary, dagger and asterisk codes.

NOTE:

Please note that these rules were designed to govern the electronic submission of ICD-10 codes and not printed claims or the capturing of ICD-10 codes by the front end GUI (Graphical User Interface), although most of the principles can also be applied to printed claims.

Appendix A: Communication with Stakeholders

Year of Publication	Date of Publication	Circular Reference	Circular Title
2004	1 October 2004	46/2004	Implementation of ICD-10 coding
	17 December 2004	58/2004	ICD-10 coding process
2005	14 June 2005	23/2005	Final ICD-10 implementation plan
	28 June 2005	25/2005	ICD-10 coding requirements for clinical support and allied health professionals
	25 July 2005	32/2005	Update on the implementation of ICD-10 coding: all you need to know
	18 August 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
	29 September 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
	3 November 2005	10/2005 (PMB data)	ICD-10 compliance statistics: communication to providers
	7 November 2005	64/2005	National Task Team on implementation of ICD-10: collection of high level data from medical schemes
	8 December 2005	12/2005 (PMB data)	Most recent circular with ICD-10 coding for PMB conditions
2006	4 May 2006	21/2006	Postponement of phase 4 of ICD-10 implementation: clinical validation
	10 May 2006	23/2006	Development and use of Quick Reference Code (QRC) lists for ICD-10
	25 July 2006	33/2006	Validity of Unspecified, Other Specified, Sign & Symptom and Default ICD-10 Codes
	28 Sept 2006	42/2006	ICD-10 Version 2 (2005) products and updating of the BHF/DXS ICD-10 master industry table
	28 Sept 2006	43/2006	ICD-10 Coding of Mixtures on Medicine Claims
	15 November 2006	47/2006	Submission of Aggregated ICD-10 Compliance Data
2007	01 Feb 2007	4/2007	SA-Specific ICD-10 Codes for Multi and Extensively Drug-Resistant Tuberculosis
	16 July 2007	19/2007	Submission of Paper Claims With ICD-10 Codes
	16 July 2007	20/2007	Claims Rejection for Invalid or Incomplete ICD-10 Codes
	20 July 2007	21/2007	ICD-10 Master Industry Table 2007 and BHF/DXS Browser - New Edition Available
	13 August 2007	24/2007	Criteria for Coding Training Companies and Trainers to be listed on the CMS Website and the ICD-10 Task Team Review Documents
	24 August 2007	27/2007	The Use of U98 Non-Disclosure ICD10-Codes
	24 August 2007	28/2007	Inclusion of an ICD-10 code at Header Level by referring Healthcare Providers
	04 October 2007	37/2007	National Task Team on ICD-10 Implementation - X59 Exposure to unspecified factor
	06 November 2007	41/2007	Addendum to Circular Number 24 of 2007 - Criteria for Coding Training Companies and Trainers to be listed on the CMS Website and the ICD-10 Task Team review documents

Year of Publication	Date of Publication	Circular Reference	Circular Title
2008	12 March 2008	7/2008	Changes to ICD-10 Master Industry Table
	21 August 2008	23/2008	ERRATA ON THE ICD-10 MIT
	18 December 2008	37/2008	Submission of aggregated ICD-10 compliance data for 2009
2009	8 July 2009	16/2009	Validity of Unspecified, Other specified, Sign & symptom, and Default ICD–10 codes
	3 September 2009	25/2009	Proposed ICD-10 coding to be used for H1N1 ("swine flu")
	3 September 2009	26/2009	Criteria for coding training companies and trainers to be listed on the CMS website and the ICD-10 Task Team review document
	3 September 2009	27/2009	Including ICD-10 code(s) on claims for treating and referring healthcare providers
	3 September 2009	28/2009	Including ICD-10 code(s) for referring healthcare providers
2010	22 February 2010	08/2010	Submission of aggregated ICD-10 compliance data 2010
	23 June 2010	29/2010	Clarification of ICD-10 coding for dental laboratory and technician claims
	23 June 2010	30/2010	ICD-10 codes, pre-authorisation and clinical validation requirements
	23 June 2010	31/2010	ICD-10 coding for non-medical schemes claims
	23 June 2010	32/2010	Purpose of the National ICD-10 Task Team
	24 June 2010	33/2010	The updating of the ICD-10 codes in line with the WHO data
	24 June 2010	34/2010	Review of the ICD-10 Implementation process
2011	02 February 2011	06/2011	Submission of aggregated ICD-10 compliance data 2011
2012	5 March 2012	10/2012	Circular 10 of 2012: Submission of Aggregated ICD-10 Compliance data
2013	10 April 2013	18/2013	Circular 18 of 2013: Submission of Aggregated ICD-10 Compliance Data
	21 June 2013	31/2013	Circular 31 of 2013: Implementation of the 2013 ICD-10 Master Industry Table
2014	25 March 2014	18/2014	Circular 18 of 2014: Submission of Aggregated ICD-10 Compliance Data

https://www.medicalschemes.com/Publications.aspx

Appendix B: Notices Published by the National Department of Health

Date of Publication	Notice Title
04 Apr 2012	Appointment of the ICD10 Task Team
15 Jun 2012	ICD-10 coding requirements and training (Circulars 1 and 2 of 2012) • Circular 1 of 2012: ICD-10 coding requirements • Circular 2 of 2012: Accreditation process of service providers/learners: Diagnostic and procedural coding (SAQA Qualification ID 66389)
15 Jun 2012	South African ICD-10 Coding Standards and Guidelines (Version 5)
4 December 2012	ICD-10 Implementation Review
7 December 2012	ICD-10 Master Industry Table update
20 March 2013	• ICD-10 Age Definitions • ICD-10 Frequently Asked Questions • ICD-10 Master Industry Table update
5 April 2013	ICD-10 MIT download from NDoH web site: • ICD-10 MIT Final March 2013 Excel • ICD-10 MIT March 2013 Add / Modify / Delete • ICD-10 MIT March 2013 .CSV
26 April 2013	ICD-10 Circular: No 3 of 2012: ICD-10 phase 3 notice to healthcare stakeholders
10 July 2013	Technical User Guide compiled by the Ministerial ICD-10 Task Team
13 September 2013	Ministerial ICD-10 Task Team to define standards and guidelines for ICD-10 coding implementation
01 January 2014	ICD-10 MIT 2014 01 Jan 2014 • ICD-10_MIT_2014 Changes Add Delete Modify 1 Jan 2014 • ICD-10_MIT_2014_CSV_01 Jan 2014 • ICD-10_ MIT_2014_Excel_01_Jan 2014

http://www.doh.gov.za/list.php?type=Notices

Appendix C: Explanatory Notes on MIT

The following table describes the information contained within the MIT. Please reference the *User Guide for National ICD-10 Master Industry Table for South Africa* for detailed information:

Column	Column Heading	Explanation of Headings	Data Example
A	Number	Sequential numbering of each entry in the MIT data file used mainly for sorting purposes.	
B	Chapter_No	Chapter number according to WHO Volume 1 Tabular List.	CHAPTER I
C	Chapter_Desc	Chapter description according to WHO Volume 1 Tabular List.	Certain infectious and parasitic diseases Neoplasms Endocrine, nutritional and metabolic diseases (E00-E90)
D	Group_Code	Group code indicates a group of codes that contain clinically similar conditions and follows the conventions of WHO ICD-10 Volume 1 referred to as 'block categories.	001 (A00-A09) 002 (A15-A19) 003 (A20-A28)
E	Group_Desc	Clinical description of the Group Code, referred to as 'block categories' in WHO ICD-10 Volume 1.	Intestinal infectious diseases Tuberculosis Certain zoonotic bacterial diseases
F	ICD10_3_Code	ICD-10 3-character code, not considered valid for use unless no 4th or 5th character code exists. Used together with Column J Valid_ICD10_ClinicalUse to indicate when valid for use.	A08
G	ICD10_3_Code_Desc	ICD-10 3-character code's description	Viral and other specified intestinal infections
H	ICD10_Code	ICD-10 code to maximum level of specificity. Used together with Column J Valid_ICD10_ClinicalUse to indicate when valid for use.	A08
I	WHO_Full_Desc	WHO long description for ICD-10 code in its 4- and 5-character format.	Viral and other specified intestinal infections
F	ICD10_3_Code	ICD-10 3-character code, not considered valid for use unless no 4th or 5th character code exists. Used together with Column J Valid_ICD10_ClinicalUse to indicate when valid for use.	A08

Column	Column Heading	Explanation of Headings	Data Example
G	ICD10_3_Code_Desc	ICD-10 3-character code's description	Viral and other specified intestinal infections
H	ICD10_Code	ICD-10 code to maximum level of specificity. Used together with Column J Valid_ICD10_ClinicalUse to indicate when valid for use.	A08
I	WHO_Full_Desc	WHO long description for ICD-10 code in its 4- and 5-character format.	Viral and other specified intestinal infections
J	Valid_ICD10_ClinicalUse	Indicates whether ICD-10 code listed in column H ICD10_Code is valid for clinical use or not. To be used in conjunction with columns U and V This is to ensure that only codes up to their maximum level of specificity are used. Indicated as: Y = Code VALID for clinical use N = CODE INVALID for clinical use	N
K	Valid_ICD10_Primary	Indicates whether ICD-10 code is valid in the primary / first position. Indicated as: Y = Code CAN be used in primary / first position N = Code CANNOT be used in primary / first position	N
L	Valid_ICD10_Asterisk	Indicates whether ICD-10 code is an Asterisk code or not. Indicated as: Y = Code IS an asterisk code N = Code IS NOT an asterisk code Please note that the asterisk (*) symbol is included in column H ICD10_Code.	N
M	Valid_ICD10_Dagger	Indicates whether ICD-10 code is a Dagger code or not. Indicated as: Y = Code IS a dagger code N = Code IS NOT a dagger code	N
N	Valid_ICD10_Sequelae	Indicates whether ICD-10 code is a Sequelae code or not. Indicated as: Y = Code IS a sequelae code N = Code IS NOT a sequelae code	N
O	Age_Range	Age indicator – only age information mentioned in WHO Volume 1 (Tabular List) added in range format.	
	Column Heading	Explanation	Data Example

Column			
P	Gender	Indicated as: M = Male F = Female U = Unspecified As per WHO Volume 2 Instruction Manual	
Q	Status	South African status indicator for each entry: A = Add D = Discontinue (entry not deleted from file) M = Modify	A
R	WHO_Start_Date	The WHO effective from date for new entries OR effective from date for change to entry to take effect. Date format = CCYYMMDD	20051101
S	WHO_End_Date	WHO discontinued date - when entry is no longer in use. Date format = CCYYMMDD	
T	WHO_Revision_History	WHO revision history of changes made per code as per WHO Corrigendas.	
U	SA_Start_Date	Blank if code existed prior to 2007 MIT version. Value exists if code was added after 2007 or when modification to code took place to indicate when change takes effect. Date format = CCYYMMDD	
V	SA_End_Date	South African discontinued date - when entry is no longer in use. Date format = CCYYMMDD	
W	SA_Revision_History	South African revision history of changes made per code.	
X	Comment	Additional comments per code.	Add new code

Column	Column Heading	Explanation of Headings	Data Example
L	Valid_ICD10_Asterisk	Indicates whether ICD-10 code is an Asterisk code or not. Indicated as: Y = Code IS an asterisk code N = Code IS NOT an asterisk code Please note that the asterisk (*) symbol is included in column H ICD10_Code.	N
M	Valid_ICD10_Dagger	Indicates whether ICD-10 code is a Dagger code or not. Indicated as: Y = Code IS a dagger code N = Code IS NOT a dagger code	N
N	Valid_ICD10_Sequelae	Indicates whether ICD-10 code is a Sequelae code or not. Indicated as: Y = Code IS a sequelae code N = Code IS NOT a sequelae code	N
O	Age_Range	Age indicator – only age information mentioned in WHO Volume 1 (Tabular List) added in range format.	
P	Gender	Indicated as: M = Male F = Female U = Unspecified As per WHO Volume 2 Instruction Manual	
Q	Status	South African status indicator for each entry: A = Add D = Discontinue (entry not deleted from file) M = Modify	A
R	WHO_Start_Date	The WHO effective from date for new entries OR effective from date for change to entry to take effect. Date format = CCYYMMDD	20051101
S	WHO_End_Date	WHO discontinued date - when entry is no longer in use. Date format = CCYYMMDD	
T	WHO_Revision_History	WHO revision history of changes made per code as per WHO Corrigendas.	
U	SA_Start_Date	Blank if code existed prior to 2007 MIT version. Value exists if code was added after 2007 or when modification to code took place to indicate when change takes effect. Date format = CCYYMMDD	
V	SA_End_Date	South African discontinued date - when entry is no longer in use. Date format = CCYYMMDD	
W	SA_Revision_History	South African revision history of changes made per code.	
X	Comment	Additional comments per code.	Add new code