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## Circular 27 of 2009

### Including ICD-10 code(s) on claims for treating and referring healthcare providers

It is a legislative requirement that all claims submitted to medical schemes by either the healthcare service provider or members of medical schemes should include an International Classification of Diseases – 10th Revision (ICD-10) code or codes. Circular 19 of 2007 sought 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 since 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 it can 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) do 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 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.

A statutory body established in terms of the  
Medical Schemes Act, 1998 (Act 131 of 1998)

Chairperson: Prof. W Pick Acting Registrar & CEO: P Matshidze



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## Identifying common pieces of information on a claim:

### I.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

### I.2 Common pieces of information applicable to specific portion(s) of a claim:

- Treating provider information
- Referral and/or prescriber information

### I.3 Pieces of information that are not common, and cannot be summarised:

- Detailed treatment information
- Additional information required for dental claims, pathology claims, optometric claims, and COVID claims
- Additional information for dispensed items and/or 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 I.1 and I.2) and **line detail** (described in point I.3) because "headers" typically refer to an electronic file layout / specification and therefore exclude paper representations.



## 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.

- 2.1 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**

**KYE MEDICAL SPECIALIST PRACTICE AND ASSOCIATES**

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PCNS Number : 016 000 1111111 Address : ROOM 10 WIERDA HOSPITAL  
VAT Number : 1234567/S : 777 TOWN STREET  
Telephone : +27 012 6531122 : 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

Elac. Response Required : N

Claim Number : 100000001235  
Values are VAT inclusive @ 14% and are claimed in South African Rand

Claim Totals	Collection	VAT	Gross	Discount	Claimed
99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99

Patient Name : ANNIE ANDERSON, AA  
Patient Identification : ID No.: 4801010109089 Code: 01 Date of Birth: 19480101 Gender: F  
Treating / Attending Provider : DR SIMON SPECIALISTO Referring Provider : DR GERARD GENERAL  
PCNS Number : 016 000 2222222 PCNS Number : 014 000 8888888  
HPCSA Council Number : MP1111111 HPCSA Council Number : MR22222

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

Item Service Date	Proc. code	Description	Qty	Patient	Gross	Discount	Claimed
001-00000001 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

Referring Service Provider Diagnoses

Treating Service Provider Diagnoses

Section 1.1

Section 1.2

Section 1.3

- 2.2 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

XVE MEDICAL SPECIALIST PRACTICE AND ASSOCIATES

Page: 01/01

PCNS Number : 016 000 1111111  
VAT Number : 123456789  
Telephone : + 27 012 6531122

Address : ROOM 10 WIERDA HOSPITAL  
: 777 TOWN STREET  
: WIERDA PARK 0145

MR GEORGE GREEN  
10 TOWNHOUSE COMPLEX  
155 CHURCH STREET  
WIERDA PARK  
CENTURION  
0145

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
99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99

Patient Name : ANNIE ANDERSON, RA  
Patient Identification : ID No.: 4801010109089 Code: 01 Date of Birth: 19480101 Gender: F  
Treating / Attending Provider : Referring Provider  
DR SIMON SPECIALISTO DR GERARD GENERAL  
PCNS Number : 016 000 2222222 PCNS Number : 014 000 8888888  
HPCSA Council Number : MP111111 HPCSA Council Number : MP222222  
Ref. Provider Diagnosis : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99

Item 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							

Treating / Attending Provider : Referring Provider  
DR PETER PHYSICIAN DR SIMON SPECIALISTO  
PCNS Number : 016 000 3333333 PCNS Number : 016 000 2222222  
HPCSA Council Number : MP333333 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

Item 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							

It is **your responsibility** as a service provider 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.

Should you require any further information, please contact the Council for Medical Schemes (CMS) at [support@medicalschemes.com](mailto:support@medicalschemes.com).

Your cooperation is always greatly appreciated.

**Ronelle Smit**  
Clinical Analyst