CIRCULAR

Reference:	ICD-10 Compliance Statistics
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Circular 2 of 2015: Submission of Aggregated ICD-10 Compliance Data

The health care industry is in the third and fourth phase of the ICD-10 implementation plan. Please refer to the *Notification on implementation of ICD-10 Phase 3 and 4.1* and *South African ICD-10 Technical User Guide* documents on the National Department of Health's website on www.health.gov.za/icddoc.php for details on the requirements of phase 3 and 4.1.

The Ministerial ICD-10 Task Team continues to monitor the ICD-10 implementation process across all healthcare stakeholder groups in the health information value chain. The monitoring process is intended to ensure that the implementation process is in line with legislation and the recommendations of the ICD-10 Task Team.

The ultimate purpose is to ensure that all schemes are complying with at least the minimum ICD-10 rejection requirements.

Please note that submission of the aggregated data is mandatory. Your attention is drawn to the provisions of Section 66(3) of the Medical Scheme Act 131 of 1998, in terms of which any medical scheme which fails to furnish the Registrar with the prescribed documentation shall be liable to pay a penalty of R1 000 (one thousand Rand) for every day for which the failure continues. Penalties will be imposed on all schemes who fail to meet the deadlines.

The dates of submission of compliance data to the Council for Medical Schemes are as follows:

- January-December 2014 data to be submitted by **13 February 2015**
- January-June 2015 data to be submitted by **15 August 2015**

Appendix A of this Circular provides the new technical specification for the data submission. The data must be submitted as per the Compliance Data Grid that as published on the Council for Medical Schemes website.

Please ensure that all data submissions are sent to icd10data@medicalschemes.com.

The grid for the submission of aggregated compliance data is available on:

http://www.medicalschemes.com/files/ICD10%20Codings/CmplncSttstcsGrdVrsn2_20150107.xls

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APPENDIX A: Technical specifications for the submission of ICD-10 compliance data for 2014 - 2015

1. File specification

File format
Data will be presented in an MS Excel format.

File name
The file name will always be "administrator_yyyymm.exe", where "administrator" contains the name of the medical scheme administrator (where schemes are self-administered, the scheme name should be used), "yyyy" contains the year, and "mm" contains the month number of the current month of submission.

Example: XYZhealth_201406.txt will be from administrator XYZhealth and include data from January to June 2014.

File contents
The file will be created with aggregate data (at the discipline level) from 2014/01/01 to the end of the current month of submission.

Examples:

- File xyzhealth_201406.txt will include data from 2014/01/01 up to and including 2014/06/30 (30 June).
- File xyzhealth_201412.txt will include data from 2014/01/01 up to and including 2014/12/31 (31 December).

The following data descriptions should be used as entry criteria for the population of the grids:

- Counts of line items must represent actual paid claim line items
- Date of claim – the date of the service of the claim must be used
- Line items – each item on a claim represent a different claim line
- Reversals – if a claim is reversed in the same month/period it should be removed from the grid. If the reversal is in a different period it should be reported separately and not as part of the current grid
- Duplicate claims – if duplicate claims are rejected up front it must not be included in the grid. Only data for claim line items that are valid for payment must be included.
- Line items rejected – only reason R101 to R111 is valid for rejection of claim line items. Internal reason codes must therefore be mapped to these reason codes.
- R111 was added to count the number of external cause codes that was omitted completely.
- Columns marked ICD 1 / ICD 2 / ICD 3 / ICD 4 / ICD 5 represent the top 5 ICD-10 codes that was reported in the reporting period. This field must state the top 5 codes per discipline and include valid and invalid codes
- Columns marked Morphology / W103 was added to count the number of warning messages in each field. The morphology codes requirement together with ICD-10 codes: C00.- to D48.- which have been postponed for now. This field should only be populated if warning messages are sent out.

2. Data specification

Field names and descriptions

The following explain the data that must be included in each column. Please note that there is no limit on the number of lines – each line will represent a different discipline.

FIELD SEQ	FIELD NAME	REPRESENTATION	DESCRIPTION
Column A	Scheme Reference Number	TEXT	CMS medical scheme reference number
Column B	Scheme name	TEXT	Name of the medical scheme represented in grid
Column C	Number of beneficiaries	NUMERIC	Total number of beneficiaries registered on scheme
Column D	Average age of beneficiaries	NUMERIC	Average age of all beneficiaries
Column E	Number of options	NUMERIC	Number of registered options for scheme
Column F	Administrator name	TEXT	Name of administrator. If self-administered repeat scheme name
Column G	Year	NUMERIC	Year that is represented by the data
Column H	Month	TEXT	Number of month that is represented by the data (01, 02, …, 12)
Column I	Discipline code	TEXT (format: ###) (Representation is TEXT to retain leading zeros)	PCNS Discipline Code (3 digit code) as published by the Board of Healthcare Funders.
Column J	Discipline Code Description	TEXT	Description of the Discipline Code as published by the Board of Healthcare Funders.
Column K	Line items received	NUMERIC	Count of total claim lines received
Column L	Line items: Complete and valid	NUMERIC	Count of claims lines received with valid & complete ICD-10 codes.
Column M	Compliance percentage	NUMERIC	Percentage of complaint line items (% difference between column K and L)
Column N	Line items Rejected (e.g. Incomplete, Missing or Invalid ICD-10 codes)*	NUMERIC	*Any rejection reason related to ICD-10 coding i.e. R101 – R111
Column O	Non-compliance percentage	NUMERIC	Percentage of non-complaint line items (% difference

			between column K and N)
Column P	R101 – Primary ICD-10 code invalid	NUMERIC	Count of claim lines rejected because ICD-10 code does not exist on MIT or falls outside of the MIT current active date range (indicated in Column U & V of MIT)
Column Q	R102 Primary ICD-10 code invalid in the primary position	NUMERIC	Count of claim lines rejected because primary ICD-10 code is invalid in the primary position As per the indicator on the MIT – valid as primary code (MIT Column K - Valid_ICD10_Primary)
Column R	R103 Primary ICD-10 code incomplete	NUMERIC	Count of claim lines rejected because primary ICD-10 code is is not supplied up to the maximum level of specificity applicable: 3rd, 4th, 5th character not provided – additional important information (MIT Column J - Valid_ICD10_ClinicalUse)
Column S	R104 - ICD 10 code omitted	NUMERIC	No ICD-10 code on claim
Column T	R105 - Secondary ICD-10 code invalid (code does not exist on MIT or are not within current date range)	NUMERIC	Count of claim lines rejected because secondary ICD-10 code does not exist on MIT or falls outside of the MIT current active date range (indicated in Column U & V of MIT)
Column U	R106 - Secondary ICD-10 code incomplete (not to maximum level of specificity)	NUMERIC	Count of claim lines rejected because secondary ICD-10 code is not supplied up to the maximum level of specificity applicable: 3rd, 4th, 5th character not provided – additional important information (MIT Column J - Valid_ICD10_ClinicalUse)
Column V	R107 - dagger code omitted (supplier should amend future accounts)	NUMERIC	• Number of claim lines that had an asterisk code but the dagger code is omitted (only if information is available and not compulsory) • Dagger code indicated on MIT together with asterisk listed on MIT (Column M of MIT)
Column W	R108a – age code incorrect	NUMERIC	Count of claim lines rejected because the code is not applicable to the age of the patient [rejection only by utilization of Column O of the MIT is allowed]
Column X	R108b – gender code incorrect	NUMERIC	Count of claim lines rejected because the code is not applicable to the gender of the patient [rejection only by utilization of Column P of the MIT is allowed]
Column Y	R109 – ICD-10 code not applicable to procedure (PMBs and contracts) – applicable on the entire string of codes	NUMERIC	Count of claim lines rejected because the diagnoses are not applicable for procedure performed – only applicable if data is captured

Column Z	R110 - cannot read the ICD-10 provided	NUMERIC	Count of claim lines rejected because the ICD-10 provided is not readable/legible
Column AA	R111 – ICD-10 external cause code omitted	NUMERIC	Count of claim lines where the external cause code (ECC) has been omitted from following an S/T code somewhere in the secondary string
Column AB	U98.0	NUMERIC	Count of claim lines with U98.0 ICD-10 code in primary position
Column AC	U98.1	NUMERIC	Count of claim lines with U98.1 ICD-10 code in primary position
Column AD	Z01.6	NUMERIC	Count of claim lines with Z01.6 ICD-10 code in primary position
Column AE	Z01.7	NUMERIC	Count of claim lines with Z01.7 ICD-10 code in primary position
Column AF	Z76.8	NUMERIC	Count of claim lines with Z76.8 ICD-10 code in primary position
Column AG	Z76.9	NUMERIC	Count of claim lines with Z76.9 ICD-10 code in primary position
Column AH	Top 1 Primary Codes per discipline Valid and/or Invalid	NUMERIC	1st Top Primary Codes per discipline (Valid and Invalid)
Column AI	Top 2 Primary Codes per discipline Valid and/or Invalid	NUMERIC	2nd Top Primary Codes per discipline (Valid and Invalid)
Column AJ	Top 3 Primary Codes per discipline Valid and / or Invalid	NUMERIC	3rd Top Primary Codes per discipline (Valid and Invalid)
Column AK	Top 4 Primary Codes per discipline Valid and / or Invalid	NUMERIC	4th Top Primary Codes per discipline (Valid and Invalid)
Column AL	Top 5 Primary Codes per discipline Valid and / or Invalid	NUMERIC	5th Top Primary Codes per discipline (Valid and Invalid)
Column AM	W101 - age (only for pediatricians)	NUMERIC	Number of warning messages to advise that age of the child is not within parameters for the specific ICD-10 code as per Column O of the MIT (applies to warning sent to pediatricians only)
Column AN	W102 Gender (only for pediatricians)	NUMERIC	Number of warning messages to advise that ICD-10 code cannot be used for the specific gender as per Column P of the MIT (applies to warning sent to pediatricians only)
Column AO	W103 Morphology	NUMERIC	Number of warning messages to advise that no morphology code was supplied in addition to codes in the

			C00-D48 neoplasm range
Column AP	W104 Clinical validation for non-PMB and non-contracts	NUMERIC	Number of warning messages to advise that ICD-10 code and procedure code does not correlate with each other (this is applicable to all non-PMB claims or where no contract is in place)

3. File submission specification

E-mail address

Data files must be submitted to the Council for Medical Schemes via e-mail. All ICD-10 compliance data must be sent to icd10data@medicalschemes.com.

This e-mail address may not be used for any ICD-10 or CMS-related correspondence. Only data submissions will be accepted on this e-mail address.