



**COUNCIL FOR MEDICAL SCHEMES**

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To:

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## **CIRCULAR 32 OF 2005**

### **UPDATE ON THE IMPLEMENTATION OF THE ICD-10 CODING:**

#### **ALL YOU NEED TO KNOW**

##### **OVERVIEW**

The Medical Schemes Act 131, of 1998, makes provision for the compulsory inclusion of a diagnosis coding system on claims that health care providers submit to medical schemes. ICD-10 is a diagnosis coding standard owned and maintained by the World Health Organisation (WHO). This coding standard was accepted by all parties in South Africa as the coding standard of choice in 1996, and has been used locally for coding of mortality for a number of years.

Coding for morbidity using ICD-10 is the next logical step in the process of development of a sound health information system for South Africa. ICD-10 is currently used in approximately 50 countries worldwide.

Benefits:

1. ICD-10 coding provides a uniform and reliable tool for gathering disease-related data which allows easy storage, retrieval and analysis of information
2. Aggregated information can be used for the appropriate planning of health care needs, notably patient care, research, performance improvement, health care planning and facility management.
3. The use of codes communicates health care data in a predictable, consistent and reproducible manner.
4. It also enables fair reimbursement for health care services provided.

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A standard can only be effectively maintained if all role players comply with its requirements. These requirements have been set out by the National Task Team for ICD-10 implementation, under the leadership of the Council for Medical Schemes.

To ensure a smooth transition to coding excellence, this document provides a summary of coding requirements and contingency plans that were put in place. It is a collation of all previous circulars and communiqués regarding ICD-10 that were distributed to stakeholders, at regular intervals since February 2004.

## TASK TEAM

In January 2004, a National Task Team was established to manage the process for the introduction and standardisation of ICD-10 coding in South Africa.

All role players were invited to participate in the Task Team. Approximately 30 representatives from different health care institutions and companies in South Africa have voluntarily participated. Representatives from the Department of Health, Council for Medical Schemes, professional organisations, health care provider groups, hospital groups, medical schemes, administrators, coding experts, software providers, switching companies and a variety of other stakeholders, have actively participated in the development of ICD-10 standards and streamlining of processes.

The primary purpose of the task team was:

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

The National Task Team will remain in force and continue to hold regular monthly meetings until such time as the final phase of the implementation process has been successfully completed.

## IMPLEMENTATION DATE

ICD-10 coding is required on claims submitted for **services rendered from 1 July 2005**. Claims cannot be rejected for services provided before 1 July 2005 on the basis that no ICD-10 code is provided (unless contractual arrangements exist between the providers and medical schemes requiring ICD-10 code submission, or where ICD-10 coding is required to identify a Prescribed Minimum Benefits (PMB) condition).

## *PHASE-IN PROCESS*

The National Task Team has decided to implement a phase-in period for the application of the ICD-10 rejection rules, based on a careful analysis of:

- available compliance statistics from medical schemes
- the administrative and cost implications for health care providers and medical schemes, to deal with the claims rejections during the first three months of implementation
- readiness of practice management software and switching providers

The phase-in plan for ICD-10 coding in South Africa has been communicated through various circulars and communiqués, most notably Council for Medical Schemes Circular 23 and amended Circular 25 of 2005. These are available on the Council website at [www.medicalschemes.com](http://www.medicalschemes.com).

The National Task Team recommends that all stakeholders familiarise themselves with the information detailed in the circulars.

The implementation process of ICD 10 is monitored on an ongoing basis through regular weekly meetings of the contingency plan team, in order to deal with implementation related issues expeditiously. Following the initial implementation period, medical schemes and health care providers will need to focus on enhancing the claims submissions process, data quality and efficiency.

### PHASE 1: 1 JULY – 30 SEPTEMBER 2005

#### **NO ICD-10 CODE NO PAY, for diagnosing providers only.**

The relevant ICD-10 code must be supplied on **each line (item)** of a claim (not per line number).

Hospital accounts require ICD-10 codes to be reflected on header (claim) level only.

A sign/symptom code can be used appropriately for any situation in which no definitive diagnosis is made. The same applies to non-diagnosing providers who want to supply ICD-10 codes. Alternatively, these health care providers may use the referring provider's diagnostic code when this is available.

#### **Validity checks** during phase 1 will comprise **only**:

- The presence of a **minimum** 3-character ICD-10 code,
- The ICD-10 code(s) being alpha-numeric,
- The code(s) appearing in the ICD-10 coding manuals or industry standard table.

**No clinical validation** by medical schemes/administrators is allowed during phase 1, **UNLESS** there are existing contractual arrangements, or coding is submitted for a PMB condition.

Diagnosis coding is not limited to health care providers in private practice, therefore ICD-10 coding also applies to health care services rendered in the public sector.

During phase 1; in instances where certain **clinical support** and **allied health professionals** do not make a diagnosis for a particular patient encounter, it will not be mandatory to submit a code. Clinical support groups, allied health professionals and pharmacists have been granted exemption from ICD-10 related rejections until 1 January 2006. Please see the Council's amended circular 25 for the most recent list of exempted health care providers. However, this does not preclude these exempted providers from submitting ICD-10 codes on their claims before 1 January 2006, where they are able to do so.

Coding is mandatory if the condition for which the service was rendered is being claimed as a Prescribed Minimum Benefit.

Coding is also mandatory if the health care provider is under specific contractual agreements with the funder concerned, in which ICD-10 coding is one of the conditions of the agreement.

PHASE 2: 1 OCTOBER – 31 DECEMBER 2005

**NO VALID AND COMPLETE ICD-10 CODE NO PAY, for diagnosing providers only.**

The primary code should be in the primary/first position followed where applicable, by secondary code(s).

**Should a combination coding rule be applicable, ie. two codes to correctly describe the disease or condition (for example, with fractures, an external cause code is required), the secondary code must also be supplied.**

The ICD-10 codes must be supplied on **each line item** of a claim (not per line number).

Please refer to the definitions of valid, primary and complete codes detailed in this document.

**PLEASE NOTE:** Codes for 'unspecified' conditions (those codes which contain .8 or .9 as a fourth character) are valid and allowable and should be recognised by medical schemes.

In any situation in which a definitive diagnosis is not made, a sign/symptom code (noted as a code that begins with an "R" in the ICD-10 coding list) would be appropriate for use and considered valid in the primary position.

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**No clinical validation** by medical schemes/administrators will be allowed during phase 2, **UNLESS** there are existing contractual arrangements, or coding is submitted for a PMB condition.

### **PHASE 3: 1 JANUARY 2006 – 30 JUNE 2006**

**All** health care providers will be required to submit ICD-10 codes on **each line item** of a claim (except for hospitals which are required to submit ICD-10 codes at a header level). The referring provider's code must appear at header level, where applicable.

**No clinical validation** by medical schemes/administrators is allowed during phase 3, **UNLESS** there are existing contractual arrangements, or coding is submitted for a PMB condition.

### **PHASE 4: FROM 1 JULY 2006**

**Full implementation of ICD-10 with clinical validation of all codes supplied.**

All ICD-10 diagnosis coding will be performed as per the World Health Organisation's official rules and conventions.

### **SPECIFIC CODING REQUIREMENTS**

Dropping of the dagger (+) and asterisk (\*) symbols is relevant for the electronic environment and on paper claims.

The standard ICD-10 electronic industry table, available from the Board of Healthcare Funders (BHF), should be used as the basis of all coding in South Africa. This table was specifically created to ensure that

- ♦ all role players have easy access to a locally applicable set of codes, and
- ♦ the list can simply and easily be incorporated into any software or paper-based system for coding of claims for submission, as well as for adjudication of those claims from a medical scheme's perspective.

The list will be updated when necessary, on 1 March each year.

## PRESCRIBED MINIMUM BENEFITS

Where member benefits are limited and a claim is being forwarded for consideration as a PMB condition, the disclosure of diagnosis codes such as ICD-10 codes will be considered crucial in the decision making process. For this reason, all claims for PMB conditions require the appropriate ICD-10 code. The 'No-ICD-10 code No-pay' rule applies for services rendered for PMB conditions on or after 1 July 2005.

The Council for Medical Schemes has concluded a process of coding PMB conditions. These are posted on the CMS website coded to the 4<sup>th</sup>-character level only. A process is currently underway, to update the PMB list to the appropriate maximum character level for release to the industry by October 2005. In the interim, the current list of PMB codes will be acceptable for reimbursement and administrative purposes by medical schemes.

## LOCALLY SPECIFIC CODES (THE 'U' CODES)

In accordance with WHO guidelines, and in consultation with the WHO, the Task Team developed a limited set of codes that would be applicable in the local environment. These codes are as follows:

**U98: Non-disclosure** (3-character heading code, thus not valid)

U98.0: Patient refusal to disclose clinical information

U98.1: Doctor refusal to disclose clinical information

These codes will be carefully profiled by medical schemes.

### **U99: Multi-drug resistant tuberculosis**

This code has 4 and 5 character codes under this heading, and all are included in the standard industry table

## CLINICAL SUPPORT AND ALLIED HEALTH PROFESSIONALS

The requirement for the inclusion of diagnosis codes on claims submitted to schemes or those given to members for submission to schemes, applies to both the diagnosing and non-diagnosing providers.

**Ideally, the clinical support groups, of which radiologists and pathologists are a part, should include the referring provider's code as a compulsory code, and include their own code where appropriate, and only when it differs from that of the referring provider. The clinical support and allied health professionals' codes must be submitted on each line item of the claim.**

The requirement for these health care providers to supply codes even when no diagnosis is made will come into effect in phase 3 (1 January 2006).

#### ICD-10 CODING WHERE NO ABNORMALITY IS DETECTED

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

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

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

Routine examinations are also often carried out by radiologists and pathologists, on the request of the referring health care provider. The codes recommended for use in such examinations are the following:

#### Z01.6 Radiological examination, not elsewhere classified

##### Routine

- chest X-ray
- mammogram

#### Z01.7 Laboratory examination

### **SPECIFICITY OF ICD-10**

ICD-10 codes will be used to the highest level of specificity in South Africa. The specificity of codes is critical for assessment of appropriateness of care, resource allocation, epidemiology of diseases and health care reform.

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

This requirement for coding to the maximum level of specificity will come into effect during phase 2 of the implementation process, on 1<sup>st</sup> October 2005.

## **DIFFERENT ICD-10 CODES ON DIFFERENT CLAIMS**

Health care providers will not be penalised by medical schemes if their codes differ from other providers treating the same patient at the same time.

The issue of determining who should decide on the main diagnosis of a patient is beyond the mandate of the Task Team. The Task Team's role is to assist in slotting in ICD-10 into current common practice, not to interfere with prevailing clinical processes.

## **PLACEMENT OF CODES ON CLAIMS**

ICD-10 coding is compulsory for hospitals at a header level. For health care provider claims, it is optional for the header code to indicate the referring provider's code and for the line level it is mandatory. Coding on modifier lines is not mandatory.

## **ELECTRONIC MASTER SET OF ICD-10 CODES**

The Board of Healthcare Funders (BHF) member medical schemes have developed an ICD-10 look-up tool available on compact disc (Version 2, 2005); however, this is a stand-alone product, which cannot be integrated into other software directly from the CD. An electronic version of ICD-10 is available on this CD as an Excel spreadsheet, which can be copied and easily incorporated into software.

The aim of this product is for everyone in the industry to use the same standard list/table of codes at the lowest possible cost.

## **CODING DEFINITIONS**

### **Principal diagnosis**

The Principal diagnosis is typically the clinical condition that is ultimately determined to have caused a patient's admission to hospital, or a patient's visit to a health care provider. It is the diagnosis that is established after investigation and diagnostic tests, and is the condition that usually explains increase in resource usage. The Principal diagnosis is also known as the Primary diagnosis, Main diagnosis, Final diagnosis or Discharge diagnosis, and it may differ from the presenting or admitting diagnosis.

A complication may become the principal diagnosis.



### **Primary code**

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

### **Valid code**

A valid code is an ICD-10 code that appears in the ICD-10 coding manuals according to the World Health Organisation rules and conventions and as specified in the industry standard table. It would comprise a primary code in the primary position on a claim. During Phase 1, this code would be a minimum of 3 characters, while from phase 2 onwards; a valid code would entail the relevant 4<sup>th</sup> and 5<sup>th</sup> characters where these are specified in the references.

Please note that the dot (.) in the ICD-10 codes is not regarded as a character.

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

- **Valid** (marked as such in industry table, or as described in the ICD-10 manuals)
- **Complete** (to the highest level of specificity as per ICD-10 rules)

### **Secondary diagnosis**

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

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

External cause codes also fall under secondary diagnoses.

### **Secondary codes**

These are codes that further describe the patient's condition or the cause of the patient encounter. Examples include diabetic retinopathy, motor vehicle accident (MVA).

The rules and conventions of ICD-10 coding as set out by the World Health Organisation (WHO) are applied to assign these codes appropriately.

### **Co-morbidity**

A pre-existing condition that may or may not increase resource usage and it may co-exist with the principal diagnosis.

A co-morbidity may become a principal diagnosis if it is the main condition being treated.

### **Sequelae (late effect)**

Sequelae codes are used to indicate conditions that are no longer present but are the cause of a current problem now under treatment. Terms such as "old", "no longer present", "late effect", or "those present one year or more after onset of the causal condition" may be used to indicate a sequelae condition.

### **Rules on assignment**

- The current condition or reason for admission is coded as the **primary code**
- The sequelae code is coded as the **secondary code**.

## **TRAINING**

Training on ICD 10 diagnosis coding is not yet a recognised course in South Africa neither is it offered at academic institutions. ICD 10 coding training is currently provided by a limited number of training institutions and trainers. The quality of the training tends to vary depending on the level of exposure and accreditation status of the trainers.

There are no registered unit standards for ICD-10 training; however plans are underway through the Department of Health to introduce them.

The Task Team has made recommendations that trainers must have a clinical qualification or equivalent clinical certification, for example a nursing or medical degree or diploma, or certification in medical terminology and anatomy from a recognised institution.

It is also recommended that a trainer must have a completion certificate in ICD-10 coding up to an advanced level, or an international accreditation in clinical coding. He or she must have completed the unit standard "Plan and conduct assessment of learning". This is a SAQA requirement for 2005. The trainer should also hold an appropriate training qualification e.g. University of Johannesburg (previously RAU) or Damelin Train-the-Trainer, or similar.

The Task Team has recommended minimum ICD-10 Medical Terminology, Anatomy, Physiology and Trainer standards. These are posted on the Council's website.

It is difficult for the Task Team to provide recommendations as to which training course would offer the best training to meet the needs of the individual medical professional, allied health professional or administrative and/or support staff. The Task Team can only supply a list of training institutions whose directors and/or staff have been actively involved, and are familiar with, the National Task Team recommendations and processes.

## Training institutions

- The Foundation for Professional Development and Discovery Institute
- Africode
- Arista

## **Minimum knowledge outcomes of any ICD-10 training course:**

- The basic structure and principles of ICD-10 according to the World Health Organisation (WHO)
- All the rules and conventions of ICD-10 according to WHO
- The use of volumes 1 and 3 and introduction to volume 2
- Ability to identify ICD-10 codes
- The use of ICD-10 codes at 3<sup>rd</sup>, 4<sup>th</sup> and 5<sup>th</sup> character levels
- Assignment of ICD-10 diagnostic codes at a basic level – this involves code assignment for single conditions and the application of the combination coding rules
- Discipline specific coding of single conditions and application of combination coding rules
- Understanding of the definitions of a principal, primary and secondary diagnoses and their application in sequencing of codes.

Full understanding and knowledge of coding of complex cases require both Intermediate and Advanced ICD-10 training.

The Task Team is aware of the negative impact that the cost of training has on the number of delegates attending training courses. As a response to this concern, and to ensure broad coverage that is cost-effective; distance learning courses have been developed.

## OTHER ISSUES

### **Licensing**

There are several ICD-10 licence holders in the private sector. It is imperative that all licence holders conform to standards set out by the World Health Organisation (WHO) on the use of ICD-10.

BHF is licensed to distribute an electronic version of the ICD-10 codes to all users. Some of the requirements for the license are that BHF keep a register of all the users of ICD-10 codes.

It is hoped that the continued interaction between the National Department of Health, the Council for Medical Schemes and the private sector with the WHO would result in the granting of a single ICD-10 license for the country in the future.

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Health care providers do not require individual licenses to allow them to access the codes for facilitating claims submission.

### **Resolution of disputes related to ICD-10**

In the absence of a formal standards body, interim measures have been put in place to ensure a smooth implementation of ICD-10. Technical related issues will be referred to the Technical Task Team, provider associations, training persons or respective entities responsible for the sale of ICD-10 materials.

Each provider association will be responsible for its own constituency. Medical schemes and the Council for Medical Schemes will entertain queries and complaints pertaining to reimbursement for services rendered.

### **Privacy confidentiality and security**

It is imperative that the privacy, confidentiality and security of consumer information is maintained at all times across the value chain of health care covering providers, switching companies, medical schemes and other related parties.

Tightening of the rules of schemes and the development of individual policies by the various entities that deal directly or indirectly, with consumer information need to be adapted to ensure the privacy and security of member data and information.

Administrators, managed care providers and switching companies should be accredited on their ability to ensure confidentiality of member data or information. This process is already underway and several managed care organisations and administrators have been accredited on a range of issues including confidentiality related matters.

There are continued discussions with the Health Professions Council of South Africa (HPCSA) and other relevant stakeholders on the need to develop a framework for management of informed consent by health care providers.

### **Standards Advisory Body**

The Department of Health through the National Health Information Standards of South Africa (NHISSA) is in the process of setting up the National Health Standards Advisory Body – a standards body that will take over the functions of the implementation task team and subsequently, all the responsibilities of the standards body.

This body will ultimately be responsible for the continued maintenance and updating of ICD-10 codes, liaison with the World Health Organisation on coding related matters and the continued developments of adequate standards for privacy, confidentiality and security.

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Sincerely

A handwritten signature in black ink, appearing to read 'P. Matshidze', with a stylized, cursive script.

**Patrick Matshidze**  
**HEAD: RESEARCH AND MONITORING**