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The National Task Team on the Implementation of ICD 10 published guidelines on ICD 10 submission for health care providers, and EDIFACT standards for administrators, IT departments and other related parties; in order to facilitate effective ICD 10 submission of claims. The guidelines are the result of a collaborative effort between the Private Health Information Standards Committee (PHISC) and the National Task Team on ICD 10 implementation.

The guidelines seek to address the following issues:

1. Standardisation of the claim submission process for providers
2. Standardisation of ICD 10 transmission through EDIFACT message

You are encouraged to submit your comments on the content of the document within 14 days from the date of publication.

Please send your comments to Carrie-Anne Osman at the Council for Medical Schemes.

Your co-operation will be greatly appreciated.

Sincerely,

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GUIDELINES ON SUBMISSION OF ICD-10 CODES

National Task Team on ICD-10 Implementation

Technical Document



Private Health Information Standards Committee

AUGUST 2005

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Introduction

ICD-10 codes have now become a compulsory part of medical claims. This technical document is presented to help standardise the process as well as to alleviate problems experienced in the submission of ICD-10 codes. It consists of two parts:

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.

Part 2: Including ICD-10 codes in the Edifact MEDCLM 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 Edifact (the national standard accepted by the Private Healthcare Information Standards Committee PHISC).

It is the intent of this part of the document to set a standard for ICD-10 code transmission, especially where the Edifact MEDCLM message is used as a claim submission format between business partners.

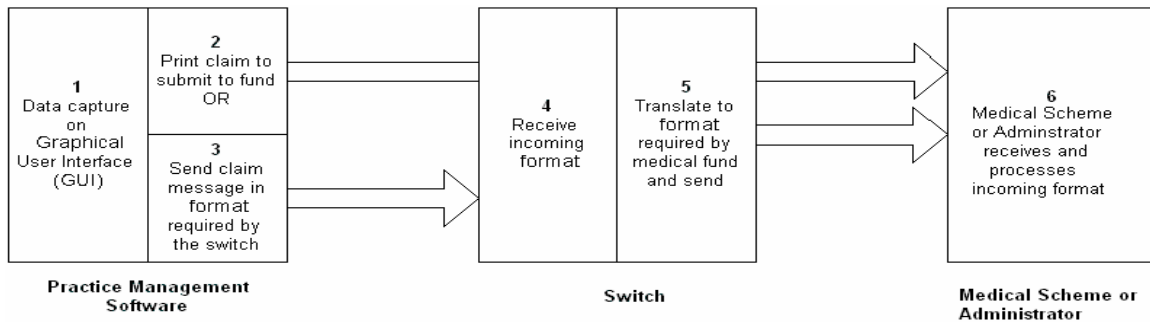
Appendix A: rules for the electronic submission of ICD-10 codes

The appendix supplies the general rules for the electronic submission of ICD-10 codes that were agreed upon by PHISC and adopted by the ICD-10 Task Team.

Part 1

Including ICD-10 codes in claim data capturing and submission

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



1. 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 practice management software should enable the practitioner to submit *referring* ICD-10 diagnoses codes on a *header* or claim level (excluding hospitals). Service providers should be able to supply *treating* ICD-10 diagnosis codes on an *item* level (on a header level by hospitals).

The functionality of the practice management 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. Three specific data capture requirements are put to the software vendors:

- 1) 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.
- 2) Although daggers (†) and asterisks (*) are omitted in electronic transmission of ICD-10 codes, PMA software systems still need to show daggers and asterisks in the GUI to enable users to correctly code clinically.
- 3) The software should guide the user to enter valid ICD-10 codes. To this end, dropdown lists with the correct codes are preferred, rather than the user typing the codes manually. Users should not need to use delimiters when typing in codes, as this should be automatically handled by the software back-end when creating

electronic claims. 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*):

a. *3rd level codes*

T14. (Dot incorrect)

T14□ (Space incorrect)

T14.□ (Space and dot incorrect)

The correct submission is: T14

b. *Multiple 3rd level codes*

T14□/T15□/T16 (Spaces follow each code before the “/” this is incorrect)

T14.□/T15.□/16. (Dots and spaces follow each code - this is incorrect)

The correct submission is: T14/T15/T16

c. *Extended code to maximum specificity*

The eventual aim is for all providers to submit valid ICD-10 codes, coded to the maximum level of specificity. The dot must then be submitted as part of the code. No spaces are allowed to follow the code or to “reserve” a field. No special character may be submitted as part of the code:

JO9.1 (Use of capital O instead of a zero 0 is incorrect)

The correct submission is: J09.1

M79.□2□/I10.5□/□K53.6□ (Incorrect - no spaces allowed)

M79-2/I10-5/K53-6 (Incorrect - no hyphens allowed)

(M79.2)(I10.5)(K53.6) (Incorrect - no brackets allowed)

The correct submission of a single code is: M79.2

The correct submission of multiple codes is: M79.2/I10.5/K53.6

2. Printing paper claims from Practice Management software

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

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 lab slip 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
18274	9/07/2005	Patient Name		28/10/1978	0182		L02.9/020.9	Acute bronchitis, unspecified	1	170.00		170.00	170.00
18274	9/07/2005				0201		778249011	3ML VOLTAREN INJECTION	1	10.17		10.17	180.17
18274	9/07/2005				0255			DRAINAGE OF SUB. ABSCESS	1	121.20		121.20	301.37
18274	9/07/2005						829102019	100ML ADCC-AMOXICYCLIN 250MG	1	24.00		24.00	325.37
18274	9/07/2005						873551001	2G ACITOP CREAM	1	18.03		18.03	343.40
18274	9/07/2005						797553002	20 500MG APEN CAPS	1	24.50		24.50	367.90
							*** Medicine	66.53					
							ED1 : 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.

3. Sending electronic claims from Practice Management software

If an electronic claim submission process is followed, the ICD-10 codes captured by the Practice Management 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 (or printed). Only the ICD-10 codes should be transmitted. This is for reasons of privacy and confidentiality (appendix A point 10).

4. Receipt of electronic claims by third parties

Electronic claims are often sent to switches, 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, e.g. layout 1.1, SuperFormat, XML or the like.

The rules in appendix A have been designed as general rules that can be applied to all of these 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. This should happen as a matter of urgency.

5. 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. E.g. where a format cannot flag 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.

6. 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 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 industry code list must be used by all parties concerned. The list is available in an electronic format from BHF.

Part 2

Including ICD-10 codes in the Edifact MEDCLM message

Edifact is an international messaging standard owned by the United Nations. It was adopted as a national standard by the Private Healthcare Information Standards Committee of South Africa (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.

1. The structure of the MEDCLM message

Message groups

The MEDCLM 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.

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, e.g.

One group 1 with one group 2:

Group 0 Header		
	Group 1	Group 2
		One or more group 3 with optionally one or more group 4
	Group 1	Group 2
		One or more group 3 with optionally one or more group 4
Group 0 Trailer		

One group 1 with multiple group 2's:

Group 0 Header		
	Group 1	Group 2
		One or more group 3 with optionally one or more group 4
	Group 2	Group 2
		One or more group 3 with optionally one or more group 4
Group 0 Trailer		

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

One group 3 with one group 4:

Group 3	
	Group 4
Group 3	
	Group 4

One group 3 with multiple group 4's:

Group 3	
	Group 4
	Group 4

2. The MEDCLM 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 MEDCLM message.

The MEDCLM 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 <i>referring</i> practitioner diagnosis goes here.
Group 2		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 <i>treating</i> practitioner diagnosis goes here (see examples for clarity).
Group 4	RFF+ICD:code/code/code/code'	Only one segment with codes up to 35 chars per segment. For medicines or consumables, the <i>treating</i> practitioner diagnosis goes here (see examples for clarity).

3. Examples of the correct submission of ICD-10 codes in the MEDCLM 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'
	RFF+CAF:0'

Group 4	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. 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, e.g:

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'
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5. 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*.

Appendix A

Rules for ICD-10 codes in electronic submission

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:

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 (/).
 - 4.1. 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.

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.