



ICD-10 IMPLEMENTATION REVIEW

JANUARY 2004 – MARCH 2010

**NATIONAL TASK TEAM ON
ICD-10
IMPLEMENTATION**

March 2010

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1. INTRODUCTION

ICD-10¹ is a diagnosis coding standard owned and maintained by the World Health Organisation (WHO). This coding standard was adopted by the National Health Information System of South Africa (NHISSA), and forms part of the health information strategy of the Department of Health. The standard currently serves as the diagnosis coding standard of choice in both the public and private sector.

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

In the South African setting, ICD-10 coding is important in that it lends itself well to the improvement of efficiency of healthcare through appropriate and standardised recording of diagnosis, analysis of information for patient care, research, performance improvement, healthcare planning and facility management. It also enables fair reimbursement for healthcare services provided and communicates health data in a predictable, consistent and reproducible manner.

Discussions around coding for morbidity began around 1999 at the Private Healthcare Information Standards Committee (PHISC) and some healthcare stakeholders indicated that ICD-10 needs to be implemented in South Africa as a matter of urgency, for many reasons. At the same time, some discussions were taking place at NHISSA. In 2000, the Council for Medical Schemes, at the request of the Minister of Health, held consultative meetings with providers and medical schemes in an effort to address concerns raised by health care providers with regards to poor payment of claims submitted on behalf of medical scheme beneficiaries. At the core of the problem was the need for greater standardisation of data collection, IT systems, and billing practices.

A process to standardise data and billing practices in the industry was started in 2001 with the formation of a Committee on Standardisation of Data and Billing practices. The Committee sought to address some of the concerns raised by providers and medical schemes. One of the key recommendations from the committee was the need for the development of appropriate coding standards for South Africa. In addition to this recommendation, the results of a survey conducted by the Council to determine the type

¹ International Statistical Classification of Diseases and Health-related problems – Tenth Revision

of information medical schemes were collecting and the quality thereof, revealed serious gaps and poor standardisation.

At the beginning of 2004, the Council for Medical Schemes, the Department of Health and industry stakeholders formed a task team whose primary purpose was to develop recommendations for an appropriate strategic plan for the successful implementation of the ICD-10 in the public and private health sector.

This document outlines the progress made to date and the recommendations made by the task team and its subcommittees with regards to operational, technical, training and confidentiality issues pertaining to the implementation of ICD-10.

1.1. Rationale of the implementation of ICD-10

The rationale behind the implementation of ICD-10 is fourfold. Firstly, there was a need to standardise data collection processes in the industry. Secondly, regulation 5(f) of the Medical Schemes Act 131 of 1998 prescribes the manner of submission of claims by health services. Thirdly, there was a need to facilitate an efficient reimbursement system, for providers that was consistent with legislation and improves risk management practices by medical schemes. And lastly, the introduction of the Medical Schemes Act in 1999 saw the emergence of a minimum set of guaranteed benefits to be covered by medical schemes. Entitlement to these benefits is diagnosis-driven and is appropriately identified using ICD-10.

1.2. National ICD-10 implementation task team

In 2004, a National Task Team on ICD-10 Implementation was formed. The task team was led by the Council for Medical Schemes and the Department of Health and included wide representation from industry stakeholders. The purpose of the task team was to develop an implementation plan and process for ICD-10 implementation in South Africa.

The task team met on a monthly basis in order to finalise the implementation plan and once the plan was implemented, the focus shifted to monitoring the implementation. All stakeholders were encouraged to provide inputs to the task team on all matters pertaining to the implementation process. The meetings now take place on a three monthly basis.

1.3. Key focus areas of the task team

The Task Team is the main decision-making body whose primary purpose was:

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

In addition to the Main Implementation Task Team; four subcommittees were formed, namely:

a) Operational subcommittee:

The operational subcommittee is responsible for the following matters:

- Licensing issues
- Communication with stakeholders
- Privacy and Confidentiality
- Assessment of public and private sector readiness
- Role of switching companies

b) Technical subcommittee:

The technical subcommittee is responsible for the following matters:

- Coding level and specificity of codes
- Adjudicate in disputes on codes
- Investigate rules and applications
- Primary vs. secondary diagnosis definitions
- Collation and maintenance of a South African ICD-10 Master Industry Table
- Collation and maintenance of a SA ICD Coding Standards Document
- International investigations of ICD-10 changes/updates (collaborate with WHO)

c) Training subcommittee

The training subcommittee is responsible for the following matters:

- Minimum training standards for ICD-10 coding
- Recommend training material and processes
- Recommend training institutions
- Recommend accreditation and qualifications for training

d) Confidentiality subcommittee

The confidentiality subcommittee is responsible for the following matters:

- To develop a framework for informed consent from medical scheme members and
- Inter-provider referrals

1.4. ICD-10 Implementation Plan

The task team developed an implementation plan for ICD-10 which entailed a phasing-in period starting on 1 July 2005. The phasing in process entailed four periods that are described below:

1.4.1. Phase 1: Implementation period 1 July to 30 September 2005

The implementation of ICD-10 from July 1 2005 entailed mandatory submission of ICD-10 codes by all health care providers except pharmacists, clinical support and allied health care providers. The mandatory submission of ICD-10 codes by these groups was postponed until 1 January 2006. But, if the condition for which the service was rendered was a Prescribed Minimum Benefit or a requirement as part of a contractual agreement, ICD-10 coding was mandatory for all health providers (including pharmacists and clinical support and allied health care providers).

A “no code no pay” principle applied during this phase. During this initial phase, a code per line item was required. The expected code had to have a minimum of three digits and be alpha numeric, and had to appear as per the ICD-10 manuals or the BHF/DXS ICD-10 Master Industry Table. No clinical validation or validation of primary codes was effected during this phase for routine claims, outside of existing contractual arrangements and the Prescribed Minimum Benefits (PMB) list. An active monitoring system to monitor turn-around times for the reimbursement of health care providers was developed and implemented.

- Mandatory submission of ICD-10 codes for diagnosing providers.
- During Phase 1, in instances where pharmacists, clinical support and allied health care providers do not make a diagnosis for a particular patient encounter, it was not mandatory to submit ICD-10 codes.
- Clinical support groups, allied health care providers and pharmacists were granted exemption from ICD-10 related rejections until 1 January 2006. However, this did not preclude these exempted providers from submitting ICD-10 codes on their claims before 1 January 2006, where they were able to do so.
- ICD-10 coding was mandatory for all healthcare professionals (including pharmacists, clinical support and allied health care providers) if the condition for which the service was rendered was being claimed as a Prescribed Minimum Benefit.

- ICD-10 coding was also mandatory if the health care provider was under specific contractual agreements with the medical scheme concerned, in which ICD-10 coding is one of the conditions of the agreement.
- A “no ICD-10 code(s) - no pay” principle applied, for diagnosing providers only.
- The relevant ICD-10 code(s) had to be supplied on each line (item) of a claim, thus it would be acceptable if the information about a service containing the ICD-10 information were reflected on more than one line, for that specific service. All the information pertaining to a service does not have to be reflected on a single line entry, although it should be regarded as one entity.
- If not all ICD-10 codes can be accommodated on the same line as the procedure code, the ICD-10 codes can be strung along on the line below the main entry, not above, as per recommended standards.
- The order of the ICD-10 codes may not be changed during the transmission process.
- Hospital accounts require ICD-10 codes to be reflected on the highest (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(s) when this is available.
- The combination coding rules pertaining to the WHO rules for dagger and asterisk codes and sequelae codes was followed during the first phase.
- Validity checks during phase 1 comprised 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 from the World Health Organisation or the BHF/DXS ICD-10 Master Industry Table available from the Board of Healthcare Funders (BHF)
- Clinical validation or validation of primary codes by medical schemes or administrations was not allowed during phase 1, unless there were existing contractual arrangements, or coding was submitted for a Prescribed Minimum Benefits (PMB) condition.
- Diagnosis coding is not limited to health care providers in private practice, therefore ICD-10 coding also applies to healthcare services rendered in the public sector.
- Summary of Phase 1: 1 July to 30 September 2005
 - Claim where diagnosis is made and supplied – No ICD-10 code = No payment
 - Any claim for a PMB condition – Valid ICD-10 code required

- Any claim under contractual arrangements – Valid ICD-10 code required
- Claim where no diagnosis is made – ICD-10 not mandatory
- In Phase 1 a VALID code was an ICD-10 code that must appear as per the specifications and rules contained in the ICD-10 set of books (World Health Organisation books) or the BHF/DXS ICD-10 Master Industry Table.

1.4.2. Phase 2: Implementation period 1 October to 31 December 2005

All health care providers except pharmacists were required to provide a valid primary ICD-10 code in the primary field. In the event that a secondary code was required, the code was also validated during this phase. All codes were to be coded to the correct level of specificity (3rd, 4th or 5th level, as appropriate). Medical schemes were encouraged to accept a code for unspecified conditions submitted by health care providers, unless it was stipulated differently in their contractual arrangements or related to PMBs. There was to be no clinical validation of codes outside of existing contractual arrangements and PMBs.

- No valid AND complete ICD-10 code - no pay, for diagnosing providers only.
- Mandatory submission of codes for diagnosing providers.
- ICD-10 coding was mandatory for all healthcare professionals if the condition for which the service was rendered was being claimed as a Prescribed Minimum Benefit.
- ICD-10 coding is also mandatory if the health care provider is under specific contractual agreements with the medical scheme concerned, in which ICD-10 coding is one of the conditions of the agreement.
- The primary code should be in the primary/first position followed where applicable, by secondary code(s).
- Should a combination coding rule be applicable, i.e. two codes to correctly describe the disease or condition (for example, with fractures, an external cause code is required, etc), the secondary code(s) must also be supplied.
- The ICD-10 codes must be supplied on each line item of a claim.
- All codes should be coded to the correct level of specificity, 3rd, 4th and 5th level. In some cases the 3-character code is the correct level of specificity (e.g. I10)
- ICD-10 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.

- No clinical validation by medical schemes or administrators will be allowed during phase 2, unless there are existing contractual arrangements, or coding is submitted for a PMB condition.
- In summary Phase 2: 1 October to 31 December 2005:
 - Claim where diagnosis is made and supplied – Valid AND complete ICD-10 code(s) required
 - Any claim for a PMB condition – Valid AND complete ICD-10 code(s) required
 - Any claim under contractual arrangements – Valid AND complete ICD-10 code(s) required
 - Claim when no diagnosis is made – ICD-10 code not mandatory
- In Phase 2 and subsequent phases – a VALID code was an ICD-10 code that must appear as per the specifications and rules contained in the ICD-10 set of books (World Health Organisation books) or industry standard table (ICD-10 Master Industry Table [MIT]). The code should also be at its appropriate 3rd, 4th or 5th character level (a COMPLETE code), which is used in compliance with the rules governing its application.

Example 1: A VALID code is one that is a primary code placed in the first position on a claim line, i.e. the relevant code describing the main reason why the medical scheme beneficiary consulted the health care professional.

Example 2: If the reason a medical scheme beneficiary is seen is due to a complication of an underlying illness, the primary code is the relevant code for the underlying illness while secondary codes describe the particular complications that the medical scheme beneficiary presents with. In this case, the VALID primary code is for the underlying illness.

- Asterisk (*) codes and external cause codes (ECC) are valid ICD-10 codes, but they are not valid as primary diagnostic codes therefore should only be used in the secondary position. Combination coding rules for external cause of injury codes and poisoning codes applies.
- A COMPLETE ICD-10 code means any code coded to its highest level of specificity at its appropriate 3rd, 4th or 5th character level.

Example: Code S72.3 (Fracture of shaft of femur) is not complete, as more detail of the diagnosis is required, namely, if it was an open or closed fracture. The COMPLETE code for an open fracture femur shaft is S72.31.

1.4.3. **Phase 3: Implementation period 1 January to 30 June 2006**

All health care providers are required to submit claims with complete codes (3rd, 4th or 5th character codes, as appropriate). The validation process for primary and secondary codes continues during this phase. However, there is no clinical validation of codes outside existing contractual arrangements and PMBs.

- ALL health care providers, including pharmacists, clinical support and allied health care providers, must submit claims with complete ICD-10 codes (3rd, 4th and 5th character codes) [in some cases the 3-character code is the correct level of specificity (e.g. I10)] on each line item of a claim (except for hospitals which are required to submit ICD-10 codes at the highest [header] level of a claim). The referring provider's ICD-10 code(s) must appear at the highest (header) level of a claim, where applicable.
- The validation process for primary and secondary codes continues during this phase.
- No clinical validation by medical schemes or administrators is allowed during Phase 3, unless there are existing contractual arrangements, or ICD-10 coding is submitted for a PMB condition.

1.4.4. **Phase 4: Implementation period 1 July 2006 onwards**

This phase was postponed for a number of reasons. It has been decided that phase 4 will be implemented in a further phased approach. The initial implementation will address ICD-10 validation aspects, for example gender validations, followed by the implementation of ICD-10 sub-sets and age edits where possible. Proper clinical validation of diagnostic against procedure/pharmaceutical codes will take place at a later stage

Important note about the implementation of Phase 4:

On March 15, 2006 at the ICD-10 Main Implementation Task Team meeting it was agreed to postpone the implementation of Phase 4 until further notice. Phase 3 therefore continues. Please refer to Circular 21 of 2006 (dated May 5, 2006) from the Council for Medical Schemes for more information about the postponement of Phase 4: Clinical validation.

2. REPORT OF THE OPERATIONAL SUB-COMMITTEE

2.1. Background

Participation includes coding experts, software providers, switching companies, Department of Health representatives, professional organisations, provider groups, hospital groups, medical schemes and administrators.

2.2. Terms of reference

The operations sub-committee is responsible for the following matters:

- ICD-10 Licensing issues
- Communication with stakeholders
- Privacy and Confidentiality
- Assessment of public and private sector readiness
- Role of Practice Management Software and switching companies

2.3. ICD-10 Licensing

It has since been established that there are two types of licenses for ICD-10 that currently exists in the country. The first type is a license owned by the public sector for sole use in the public sector. The second type of licence is that owned by individual companies. These licenses allow use or distribution of ICD-10 codes in the private sector, either in print or in electronic format. Each license from the WHO was subject to different licensing terms. Since it is imperative that all license holders conform to standards set out by the WHO on the use of ICD-10, the Operations Sub-committee deemed it appropriate to approach the WHO for guidance regarding the adoption of ICD-10 nationally, and to ascertain whether any changes to current licensing would be necessary.

The Operations sub-committee collated all available information regarding the existing license holders and submitted this information to the WHO together with a letter outlining our concerns and queries, in June 2004.

The WHO responded as follows:

- a. The existing licenses remain valid, and no new license would need to be granted in the short term to allow implementation of ICD-10. The organization expressed satisfaction that South Africa has

adopted ICD-10 but made it absolutely clear that ICD-10 should be used as prescribed by WHO in order for local statistics to hold any value internationally.

- b. Longer term, 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. To this end, the establishment of a national standards body would be seen as a first step towards the granting of a single national license for ICD-10.
- c. It was further confirmed through discussions with WHO, that it is an express condition of all licenses that no fee may be charged for the distribution of ICD-10, except such fees as may be appropriate to cover distribution (print or electronic formats) or installation and integration costs for software packages.
- d. More importantly, since ICD-10 exists in the public domain, it was stated that no profit may be earned through any value-added packages or products, for the use of ICD-10 in such products.
- e. The WHO also confirmed that healthcare providers do not require individual licenses in order for them to access the codes for facilitating claims submission.

The Board of Healthcare Medical schemes (BHF) holds a license from the World Health Organisation which allows distribution of an electronic version of the ICD-10 codes, to all stakeholders in the private sector. Some of the requirements for the licence are that BHF keep a register of all the users of ICD-10 codes and software providers have assisted with this task too. The development and maintenance of the electronic ICD-10 list (the BHF-DXS Master ICD-10 list) has been one of the main tasks of the Operational sub-committee.

Standardisation of ICD-10 in the form of an electronic list has ensured that software developers, switching companies and other stakeholders have access to ICD-10 lists. This has had the effect that all stakeholders have access to the standard ICD-10 list for South Africa.

2.4. Communication with stakeholders

One of the most important tasks of the Operations sub-committee is to communicate all decisions made by the National Implementation Task Team. This is not without its challenges, since the audience is

broad and very varied. Regular Task Team meetings have been, and continue to be, held monthly. The meetings are open to all stakeholders, and attendance is always good.

In addition, the Operational sub-committee has compiled and published regular circulars on the CMS website. These are official documents outlining the various rules and guidelines relating to the use of ICD-10 in general, and the application of ICD-10 coding in South Africa, as well as reports on the status of the ICD-10 implementation project.

Official communications are listed below, and are available on the above-mentioned website:

<i>2004 CMS Circular #</i>	<i>Title</i>	<i>Date of Publication</i>
46/2004	Implementation of ICD-10 coding	1 October 2004
58/2004	ICD-10 coding process	17 December 2004
<i>2005 CMS Circular #</i>	<i>Title</i>	<i>Date of Publication</i>
23/2005	Final ICD-10 implementation plan	14 June 2005
25/2005	ICD-10 coding requirements for clinical support and allied health professionals	28 June 2005
32/2005	Update on the implementation of ICD-10 coding: all you need to know	25 July 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	18 August 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	29 September 2005
10/2005 (PMB data)	ICD-10 compliance statistics: communication to providers	3 November 2005
64/2005	National Task team on implementation of ICD-10: collection of high level data from medical schemes	7 November 2005
12/2005 (PMB data)	Most recent circular with ICD-10 coding for PMB conditions	8 December 2005
<i>2006 CMS</i>	<i>Title</i>	<i>Date of Publication</i>

<i>Circular #</i>		
21/2006	Postponement of phase 4 of ICD-10 implementation: clinical validation	4 May 2006
23/2006	Development and use of Quick Reference Code (QRC) lists for ICD-10	10 May 2006
33/2006	Validity of Unspecified, Other Specified, Sign & Symptom and Default ICD-10 Codes	25 July 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	28 Sept 2006
47/2006	Submission of Aggregated ICD-10 Compliance Data	15 November 2006

<i>2007 CMS Circular #</i>	<i>Title</i>	<i>Date of Publication</i>
4/2007	SA-Specific ICD-10 Codes for Multi and Extensively Drug-Resistant Tuberculosis	01 Feb 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	16 July 2007
21/2007	ICD-10 Master Industry Table 2007 and BHF/DXS Browser - New Edition Available	20 July 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	13 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	24 August 2007
37/2007	Circular 37 of 2007 - National Task Team on ICD-10 Implementation - X59 Exposure to unspecified factor	04 October 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	06 November 2007

<i>2008 CMS</i>	<i>Title</i>	<i>Date of Publication</i>
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<i>Circular #</i>		
7/2008	Changes to ICD-10 Master Industry Table	12 March 2008
23/2008	ERRATA ON THE ICD-10 MIT	21 August 2008
37/2008	Submission of aggregated ICD-10 compliance data for 2009	18 December 2008

<i>2009 CMS Circular #</i>	<i>Title</i>	<i>Date of Publication</i>
16/2009	Validity of Unspecified, Other specified, Sign & symptom, and Default ICD–10 codes	8 July 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	3 September 2009

<i>2010 CMS Circular #</i>	<i>Title</i>	<i>Date of Publication</i>
08/2010	Circular 8 of 2010: Submission of aggregated ICD-10 compliance data 2010	22 February 2010

Details of the content of each of these circulars are provided in the reports of the Technical Sub-committee of the National Task Team, as well as the Training Sub-committee where appropriate.

2.5. Confidentiality

Confidentiality is used as a generic term that includes privacy, confidentiality and security of patient information. The issue of confidentiality straddles a variety of legislative provisions. There are also operational implications regarding the transmission of patient information from one point to the next. As a result, the task team agreed to the formation of a committee that will focus solely on the development of a framework for the maintenance of patient confidentiality. In March 2006, a sub-committee on

confidentiality of patient information was formed. In line with the ICD-10 patient confidentiality subcommittee report of 2007, the ICD-10 Operational sub-committee is also represented on the PHISC sub-committee tasked with the practical implementation guidelines in terms of the recommendations highlighted within the report.

2.6. Assessment of public and private sector readiness

The phase-in process was developed to minimise the impact of operational and change management issues on the implementation of ICD-10. It also became necessary to form a contingency team that would deal with urgent operational and other issues impacting on the implementation process. Initially, the team met on a weekly basis, however once the process stabilised, it met monthly.

2.7. Role of software and switching companies

One of the important stakeholders in the implementation of ICD-10 has been software houses and switching companies who manage and process patient information from providers to medical schemes on a daily basis. The participation of these entities helped in the development of appropriate electronic standards for the transmission of ICD-10 codes. There is also sufficient representation within this sub-committee from these specific stakeholders.

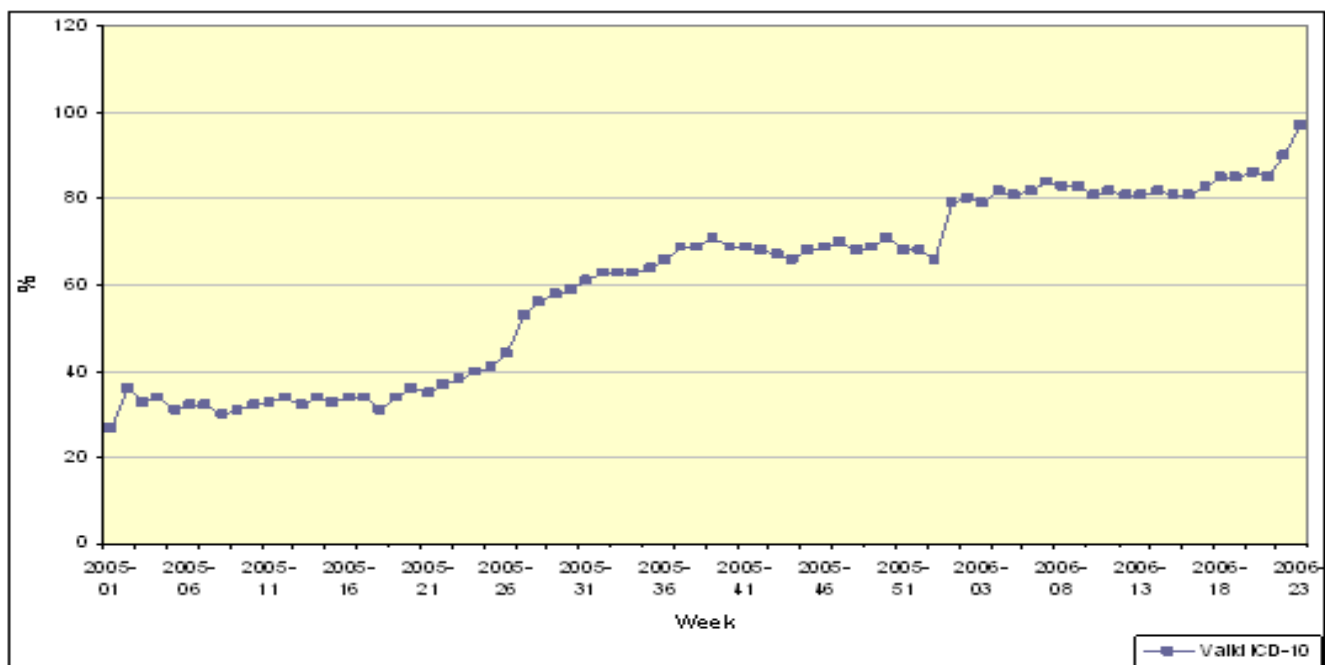
2.8. Standards Advisory Body

The Department of Health, through NHISSA, is in the process of setting up a standards body to be called the National Health Standards Advisory Body. Once established, this body should be able to take over the functions of the implementation task team and subsequently all the responsibilities of the standards body.

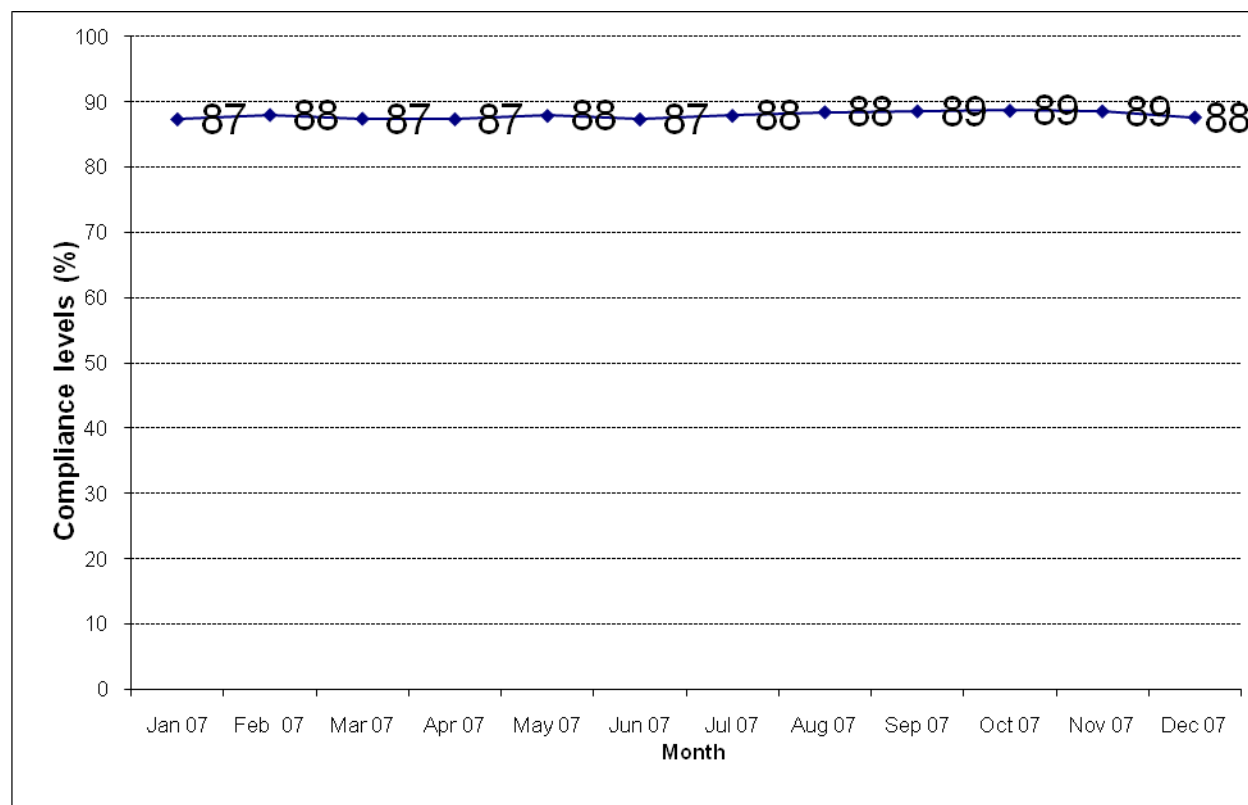
Over time, this body will be responsible for the continued maintenance and updating of ICD-10 codes, liaison with the WHO on coding related matters and the continued developments of adequate standards for privacy, confidentiality and security.

2.9. Compliance Statistics

The graphs below give an indication a trend analysis of all the data from different healthcare providers from the 1 July 2005 when ICD-10 was implemented till May 2006.



The Graph below indicates the compliance and adherence to submitting ICD-10 codes as a percentage of all claims. This is for the period January to December 2007



3. REPORT OF THE TECHNICAL SUBCOMMITTEE

3.1. Terms of reference for the ICD-10 Technical Subcommittee

- To standardise coding practices of ICD-10
- To develop consensus on the specificity of ICD-10
- To develop criteria for submission of ICD-10 for all health care providers

3.2. Purpose of this Subcommittee

To compile a document containing standardised ICD-10 coding principles for South Africa. The compilation of a 'Standards Document' for all technical decisions taken is essential to ensure uniform diagnostic coding in South Africa.

3.3. Diagnosing versus non-diagnosing providers

The Task Team resolved that it was beyond its mandate to make a determination on who are the diagnosing providers and who are not. This was considered to be the domain of professional regulatory bodies. The Task Team's role is to assist in encouraging appropriate ICD-10 coding and to entrench it into the current common practice.

3.4. Legal obligation to add ICD-10 codes on accounts or claims

Regulation 5(f) of the Medical Schemes Act, 131 of 1998, outlines legislative requirements for adding diagnostic information to accounts/claims.

It was agreed by the Task Team that ICD-10 code(s) must be provided by the attending health care provider. This includes health care providers rendering supporting services such as radiology and pathology.

3.5. Placement of ICD-10 codes on claims

The ICD-10 code(s) is placed on each line item of service rendered on an account, statement or claim. The referring health care provider's ICD-10 code(s) are reflected at the highest summary level. Please

note that some people and/or organisations could refer to the summary sections as levels of a claim, or headers and sub-headers, but we encourage everyone to refer to these sections **as summaries** and **line detail** because 'headers' typically refer to an electronic file layout/specification and therefore excludes paper representations.

It is the health care provider's **responsibility** to ensure that the correct and appropriate ICD-10 codes to describe all patient encounters are selected and to be familiar with their software program's input requirements for ICD-10 codes. When a claim is submitted through to medical schemes for reimbursement purposes, the health care provider must ensure that the practice management software application (PMA) and/or electronic switching company that they are contracted with, adheres to these claim submission guidelines. If the health care providers are unsure about their PMA's accuracy or capability, or if they have received messages regarding incorrect codes on their medical scheme reconciliation statements, the health care providers should contact their PMA vendor directly. If the health care providers are not using commercially available software, they have to ensure that the software program has the required capability to guarantee correct coding submissions.

Please refer to Circular 27 or 2009: *Including ICD-10 code(s) on claims for treating and referring health care providers*, for more information on where on a claim the ICD-10 information should be presented.

In the case of hospital claims, the ICD-10 code(s) is compulsory only at the highest level i.e. header level or level 1. This means that ICD-10 codes do not have to be specified at line item level (detailed service items).

However, claims submitted by treating health care providers (non-hospital) must carry ICD-10 code(s) at each individual line item claimed. Even if the same ICD-10 code(s) is clinically applicable to all the line items (procedure tariff codes, material or NAPPI codes) within that claim, the ICD-10 code(s) must be repeated against each line item. Because of the clinical nature of ICD-10 codes, it is the responsibility of the health care provider to explicitly indicate which ICD-10 code(s) apply to each individual claim line item.

Each and every item on a claim for services rendered must be coded to the highest level of specificity. This includes claims for:

- Consultations
- Procedures
- Dispensed items

- Any other item appearing on a claim, relevant to the patient encounter.

Provision of ICD-10 codes at the highest summary level (header level) of the claim would only be required to reflect the referring health care provider's diagnostic code(s). This however, remains optional but does not preclude the health care provider from providing all other details that should be included at the highest summary level (header level). While the population of the referring health care provider's information and diagnostic code(s) into the appropriate data field(s) is not mandatory, it must be noted that the **existence of this field is mandatory**. All parties are therefore requested to ensure that fields containing referral diagnoses data are not discarded in the transmission of data to or at the medical scheme. Healthcare providers are encouraged to at all times provide referring ICD-10 code(s) when patients are referred to other health care providers. This would enable non-diagnosing practices to add information to the patient's account, for example, diagnosis that are considered part of the Prescribed Minimum Benefits (PMBs) thus allowing these services rendered to also be paid from the benefit pool for PMBs.

Use of ICD-10 codes on modifier lines

The use of ICD-10 codes on modifier lines is not mandatory, except for modifier 0017: *Injections administered by medical practitioners*. An ICD-10 code(s) is required to indicate the diagnosis when modifier 0017 is used. 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.

Including ICD-10 code(s) for referring health care providers

ICD-10 codes should be included from a referring health care provider on a claim rendered by a health care provider that might not necessarily have "treated" a patient but is reporting on a patient's medical condition or has provided medical services, e.g. tests or prosthetics, that will assist the treating health care provider in addressing a patient's medical condition.

Where the attending service provider's practice type (discipline and sub-discipline) is considered to be a non-diagnosing practice type, the ICD-10 code(s) supplied on line item level will mostly be unspecified or default codes because a diagnosis can typically not be made due to the nature of the practice. Each line item's ICD-10 code(s) can then not be used to determine the benefit allocation for the patient.

In this case, the referral diagnosis could be used to determine the condition(s) of the patient/member in order for the medical scheme to ensure correct benefit allocation. (Refer to Circular 28 of 2009: *Including ICD-10 code(s) for referring healthcare providers* for more detailed information.)

Validity and specificity of ICD-10 codes

For an ICD-10 code to be considered valid, it must be reflected at the highest level of specificity as determined by the coding rules of the World Health Organization (WHO) and the *South African ICD-10 Coding Standards* document. 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. These codes cannot be rejected by medical schemes. 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.

"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 electronic BHF/DXS ICD-10 Master Industry Table. These codes are valid and cannot be rejected by medical schemes since in some cases no more specific information is available to code a more specific code. (Refer to Circular 16 of 2009: *Validity of Unspecified, Other specified, Sign & symptom, and Default ICD-10 codes*).

Dental laboratory and 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 ICD-10 Coding Standards* 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 Prescribed Minimum Benefit (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*).

3.6. Prescribed Minimum Benefits (PMBs)

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 chronic conditions and emergency medical conditions. All of these benefits are identifiable through a diagnosis code.

In terms of Regulation 5(f) of the Medical Schemes Act, 131 of 1998, there is a minimum set of information that needs to appear on an account submitted to a medical scheme either by a member of a medical scheme or a health care provider who rendered a service to a member, for purposes of confirmation of service(s) and reimbursement of the health care provider.

A diagnosis is one such requirement stipulated in the regulations. This allows the medical scheme to identify and allocate health care benefits thus guaranteeing access to health for medical scheme members, including statutory benefits such as Prescribed Minimum Benefits. The diagnosis also facilitates appropriate and timeous reimbursement of providers for relevant health services rendered. It also supports health care reform processes such as the Risk Equalisation Fund (REF), by providing a tool with which to identify all the relevant medical conditions.

Therefore, access to these benefits can only be achieved through the correct disclosure of an ICD-10 code(s). Currently, all PMBs are coded, thus making it easy to identify them using ICD-10 codes (refer to the website of the Council for Medical Schemes www.medicalschemes.com for the latest information). For purposes of appropriate identification of PMBs, all claims for PMB conditions require the appropriate ICD-10 codes to their full specificity. Coding of all diagnoses is important as the 'No ICD-10 code(s) - no pay' rule applies for services rendered for PMB conditions already from 1 July 2005.

All medical scheme members expect their medical scheme to honour their claims regarding all the services that they would access, for as long as this falls within the basket of services they would have chosen when they joined the medical scheme. This is based on the fact that the member will provide the

medical scheme with all the relevant information, including diagnosis information, pertaining to the determination of their health care entitlement.

Non-disclosure of a diagnosis by the member of a medical scheme or the health care provider

There are instances where the member or the health care provider might refuse to disclose a diagnosis to a medical scheme for a variety of reasons. In such cases, provision has been made by the ICD-10 Task Team for use of non-disclosure codes under the U98.- code range. However, under such circumstances, the medical scheme is under no obligation to reimburse the member or the health care 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.

When U98.- codes are used, the medical scheme is unfortunately unable to determine what health care services the member received in order to assign benefits accurately and appropriately. It makes the process of claims adjudication difficult for medical schemes. The medical scheme is also not able to determine whether the condition is a PMB or not. Non-disclosure of a diagnosis tends to undermine the REF process as the scheme is unable to determine the impact of REF.

The use of a U98.- code on its own or as part of a string of ICD-10 codes may result in non-payment of the claim to either the health care provider or the member. In instances where the member refuses to disclose diagnostic information, the health care provider should inform the member of the implications thereof regarding non-payment of the account by the medical scheme. On the other hand, medical schemes are encouraged to take the responsibility of communicating the reason for non-payment of the account to their members. (Refer to Circular 27 of 2007: *The use of U98 non-disclosure ICD-10 codes.*)

3.7. Specific rules in terms of ICD-10 coding

- If a provider makes a diagnosis, he/she will need to supply ICD-10 code(s), even on pre-paid accounts, 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.
- In order to protect a patient's privacy and keep their medical encounter's details confidential, only the ICD-10 code(s) should be reflected on the claim/account and not the description of the ICD-10 code.

- A patient or member (3rd party) may not code an account or prescription themselves; the coding has to be done by the health care provider or practice rendering the service. As with all other codes, it is the health care provider's responsibility to provide this information in an accurate and reliable manner.
- As per ICD-10 conventions, a health care provider should not code suspected/query/excluded conditions until they have been confirmed – signs and symptoms must be used as interim codes which can then be updated once confirmatory results are received.
- No health care provider should be compromised if their codes differ from that of other health care providers treating the same patient at the same time.
- No claims/accounts with ICD-10 code(s) may be rejected due to clinical interpretation of coding during the first three phases of implementation, unless there are existing contractual arrangements, or coding is submitted for a Prescribed Minimum Benefit (PMB) condition. (Please note that Phase 4: *Clinical validation* was postponed until further notice). The fact that valid ICD-10 codes are supplied on line item level is sufficient.
- In circulars previously sent out by the Council for Medical Schemes it was not clearly stipulated that ALL ICD-10 codes submitted had to be valid codes (if multiple codes are submitted). There has been a misinterpretation by some role players that only one valid code was required, i.e. only the primary ICD-10 code must be valid. It is important to note that ALL codes submitted should be valid and complete as per the WHO rules and conventions.
- The use of multiple codes for one visit may be appropriate and the codes are to tie in with the rules for selection of a primary ICD-10 code and sequencing of secondary codes. The fact that two different diseases may be classified under the same code is a training issue for clarification of the ICD-10 structure and classification style.
- The use of ICD-10 Volume 1 (Tabular list) and/or ICD-10 Volume 3 (Alphabetic Index) in isolation could result in basic rules of assignment being missed. Volume 3 (Alphabetic Index) should be used to find the lead ICD-10 code(s) and Volume 1 (Tabular List) to verify that the ICD-10 code selected is the correct code for that specific diagnosis.
- Not all codes need to be coded to a 5th character!! This is also true for 4th character codes, since some ICD-10 codes are valid to three characters only. **In all circumstances a diagnosis should be coded to the full level of specificity for that specific ICD-10 code.**
- ICD-10 codes must be supplied on each line item of a claim by the treating or attending health care provider. This includes line items such as consultations, procedures, services rendered, and medicine and material codes.
- The foundation from which to work in terms of ICD-10 coding is the latest electronic BHF/DXS ICD-10 Master Industry Table (MIT) obtainable from the Practice Code Numbering System division

of the Board of Healthcare Funders (BHF) (www.bhfglobal.com). This electronic product is regarded as the health care industry standard for ICD-10 codes and contains all the ICD-10 codes used in the South African health care industry. Please note that this product is updated approximately every two years and the latest version of the ICD-10 Master Industry Table must at all times be used.

3.8. Different ICD-10 codes on different claims

Health care providers can not be penalised by medical schemes if their ICD-10 codes differ from that of other health care 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 coding into current common practice, and not to interfere with prevailing clinical processes.

3.9. Pre-authorisation versus claim use of ICD-10 codes

The following standard response was drafted 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 health care providers for the purpose of pre-authorisation or use the verbal description given by the member/health care provider for translation into a pre-authorisation/admission code. The admission code must be updated by the health care provider(s) as the patient's condition progresses or when discharge takes place."

3.10. Some reasons for rejection of claims by medical schemes

A review of claims/statements submitted since the mandatory submission of ICD-10 was begun on 1 July 2005, revealed that one of the reasons for rejection of claims by medical schemes was incorrect coding practices due to coding format errors. This however, could be eliminated by ensuring that care is taken when typing in or selecting ICD-10 codes on the claims, as invalid formatting could result in rejections.

When manually typing of codes and ICD-10 file maintenance occur, health care providers, software vendors and other relevant stakeholders should take note of the following common errors:

Error 1: Three character codes

Example: Code A09

The correct electronic and/or paper submission is: A09

Common typing/transcription errors:

A09. (Dot incorrect)

A09□ (Space incorrect) □ = space

A09.□ (Dot and space incorrect) □ = space

No spaces are allowed to follow the code.

Why does this matter?

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.

Error 2: Multiple three character codes

Example: Codes G64, G92 and G98 all apply to the same patient encounter

The correct electronic submission is: G64/G92/G98

Common typing error:

G64.□/G92.□/□ (Dots and spaces follow each code - this is incorrect) □ = space

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.

Health care 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.

Error 3: Extended codes to maximum specificity

For health care providers to submit valid ICD-10 codes, coded to the maximum specificity (i.e. 3, 4 or 5 character codes) which was the requirement for Phase 2 of the ICD-10 implementation process from October 1, 2005, the dot (.) MUST be submitted as part of the ICD-10 code when 4 or 5 character codes are used.

The correct submission is: M67.2

It is incorrect to submit the above code as M672 (thus without the dot (.))

Error 4: Multiple extended codes

The correct electronic submission of multiple codes is: M67.2/I15.0/K52.9

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 health care 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.

Common submission errors:

M67. □2□/I15.0□/□K52.9□ (Incorrect - no spaces allowed on electronic claims) □ = space

M67-2/I15-0/K52-9 (Incorrect - no hyphens allowed on electronic or paper claims)

(M67.2)(I15.0)(K52.9) (Incorrect - no brackets allowed on electronic or paper claims)

When submitting ICD-10 codes on a paper claim/statement, whether on line item level or the summary level for referring service provider's diagnoses, multiple ICD-10 codes must be separated by a space, a forward slash and another space.

For example on PAPER:

M67. 2□/□I15.0□/□K52.9 (Incorrect - no spaces allowed on electronic claims) □ = space

The reason for the difference in format submitting on paper is to ensure that whoever is reading the claim can easily identify each separate ICD-10 code, therefore increasing legibility.

Error 5: Using only the correct characters

J01.1 (Use of upper case O instead of a zero (0) is incorrect)

The correct submission is: J01.1

J01.l (Use of lower case "L" or upper case "I" instead of a one (1) is incorrect)

The correct submission is: J01.1

O86.1 (Use the zero (0) instead of the upper case O is incorrect)

The correct submission is: O86.1

ICD-10 codes all follow the same format (L = letter and N = number):

- Three-character code: *An alphabet (letter) followed by two numbers (LNN).*
- Four-character code: *An alphabet followed by two numbers, a dot (.) and another number (LNN.N).*
- Five-character code: *An alphabet followed by two numbers, a dot (.) and two numbers (LNN.NN).*
- However, for ICD-10 codes M45, T08, T10, T12, V98 and V99 where an 'X' is used as a place holder to add the fifth character at the correct position in the coding hierarchy, the format is as follows: *An alphabet followed by two numbers, a dot (.) and an 'X'; followed by a number (LNN.XN).*
- Morphology codes: *An alphabet followed by four numbers, a forward slash (/) and another number (LNNNN/N)*

Error 6: Inclusion of ICD-10 descriptions on claims

Diagnosis descriptions should NOT be included on paper or electronic claims. The reason for this rule is to maintain the patient's privacy and confidentiality.

General information regarding rejection of claims

All software vendors and switching companies must make provision for ICD-10 codes up to ten characters each and up to 10 complete codes per line.

Refer to the Council for Medical Schemes (CMS) Circulars 35 and 36 of 2005 both dated 16 August 2005 for more detailed technical errors and requirements. It should be noted that the paper claim requirements are different from that of electronic claims and are currently being addressed through the

Messaging Standards Subcommittee (previously the Software Technical Subcommittee) of the Private Healthcare Industry Standards Committee (PHISC). Notwithstanding the different requirements, ICD-10 codes must be reflected on every line item; dittos (") or brackets () may not be used on paper claims to show that the same code applies to several line items.

Submitting of paper claims with ICD-10 codes

The following is a list current claim submission trends that affect how claims are paid by medical schemes in the manner in which health care professionals are submitting paper claims

1. Codes not assigned on a line item level

Medical schemes have been receiving paper claims with valid ICD-10 codes, but have been having difficulty in allocating payment because the codes have not been assigned on a line item level. The requirement for non-hospital claims to carry ICD-10 code(s) at each individual line item level has been communicated in several past CMS circulars.

2. Using ditto characters to indicate a repeated diagnosis

Medical schemes also receive claims where ditto (") characters are used to indicate a repeated diagnosis, forcing claims assessors to assume the diagnosis allocated to the line. Please include ICD-10 codes on EACH LINE ITEM LEVEL to ensure correct payment allocation and payment. Submission of an ICD-10 code(s) on only the first line of a multi-line claim does not meet with legislative requirements. Therefore even if the same ICD-10 code(s) is clinically applicable to all the line items (procedure tariff codes, material or NAPPI codes) within that claim, the ICD-10 code(s) apply to each individual claim line. It is inappropriate for medical schemes to assume or flood down ICD-10 codes against claim lines that do not have the actual ICD-10 code(s) clearly indicated by the treating provider.

The practice of flooding codes from the highest (header) to line level is strongly discouraged as it has been found to be problematic for the following reasons:

- Possible differences in dates of service;
- Different dependants being treated at the same time;
- Inability to identify Prescribed Minimum Benefits (PMBs).

3. ICD-10 code in line below procedure code description

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. Multiple ICD-10 codes

When multiple ICD-10 codes are applicable to one line item, for example, an external cause code is coded with an "S" or "T" code, the codes should be entered on the same line.

For examples of the above, please refer to Circular 19 of 2007: *Communiqué: Submitting of paper claims with ICD-10 codes*.

3.11. Guidelines and rules for Practice Management Application (PMA) software

Practice Management Application (PMA) software vendors are expected to comply with the following guidelines and rules:

- Provide the functionality to capture ICD-10 codes, which is the domain of the PMA.
- The latest version of the electronic BHF/DXS ICD-10 Master Industry Table (MIT) must be used.
- Always code up to the highest level of specificity, 3rd, 4th and 5th characters, as appropriate.
- The user must be able to alter previously selected ICD-10 codes, when required.
- Dagger/asterisk symbols must be displayed within electronic look-up lists.
- Electronic look-up lists are preferred over the manual typing of ICD-10 codes.
- Allow a maximum of ten ICD-10 codes per line item and/or referral diagnosis.
- Allow a maximum 10-character length per ICD-10 code.
- Placeholders may be upper or lower case x / X (for example M45.x9), but must be applied when applicable.
- 3-character ICD-10 codes: No dot (.), no spaces, no hyphens.
- 4- and 5-character ICD-10 codes: No spaces, no hyphens, but include dot (.) after third character.
- Treating or attending health care providers to supply ICD-10 codes on each line item.
- Electronic claims: Delimited with forward slash (/) without spaces before and after the slash.
- Paper claims: Delimited with a space, a forward slash (/) and another space.
- Electronic and paper claims: Omit dagger/asterisk symbols.
- Paper and electronic claims: **NO** diagnostic descriptions may appear on claims.
- No ICD-10 codes for modifiers (except for modifier 0017 for medical practitioners)
- Morphology codes must be catered for and the correct code format used.
- Third parties (i.e. switching 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 of data.

3.12. Implementation of ICD-10 in the South African healthcare industry

On June 14, 2005 the Council for Medical Schemes published Circular 25 of 2005 in terms of the final ICD-10 implementation plan in which it was stated that a less rigid approach would be followed with the implementation of ICD-10 in the South African healthcare industry in order for the process to be a success. Phase 4: Implementation period 1 July 2006 onwards (postponed)

Important note about the implementation of Phase 4: Clinical validation: On March 15, 2006 at the ICD-10 National Implementation Task Team meeting, it was agreed to postpone the implementation of Phase 4 until further notice. Phase 3 therefore continues. Please refer to Circular 21 of 2006, dated May 5, 2006) from the Council for Medical Schemes for more information about the postponement of Phase 4.

3.13. Clinical validation

Clinical validation of diagnosis (ICD-10) and procedure (e.g. RPL/CCSA/CPT) matches is part of Phase 4 (postponed until further notice) of the ICD-10 implementation strategy. In anticipation of Phase 4, some schemes are already issuing information messages to providers where "mismatches" between diagnosis and procedures are being perceived. No rejection of these ICD-10 codes may result in a refusal to pay by medical schemes for the services rendered based on the "incorrect" ICD-10 code if the ICD-10 is a valid and complete code on the BHF/DXS ICD-10 Master Industry Table.

Clinical validations must take into consideration the ability for ICD-10 code sequences to change pending changes in a patient's condition and that sometimes, secondary codes (e.g. asterisks) should be used for matching conditions to procedures. Thus consistency to the industry standard must be maintained in this regard. Moreover, matching the diagnosis and treatment should not become prescriptive in nature. It will be up to each individual medical scheme to profile health care providers using treatment that differs from the norm.

The purpose of the clinical validation phase of the ICD-10 implementation is to monitor appropriateness of care by correlating diagnosis and procedure codes. However, at this stage, there is no industry standard in this regard, making such an initiative difficult. In addition, the varying sequencing rules of ICD-10 make a direct match of a primary diagnosis to a primary procedure challenging. It was agreed that the specialist groups (disciplines) should be involved in mapping this validation work.

3.14. Clinical support and allied health care providers

As of January 1, 2006, the inclusion of diagnosis codes on claims submitted to medical schemes or claims given to members for submission to medical schemes, applies to both the diagnosing and non-diagnosing providers. The clinical support groups, of which radiologists and pathologists are a part, should include the referring provider's ICD-10 code(s) as an optional code (ideally this should be compulsory), and include their own code(s) where appropriate, even if it differs from that of the referring provider. All health care providers' (including clinical support and allied health care providers) codes must be submitted on each line item of the claim.

3.15. South African ICD-10 Coding Standards

The ICD-10 Technical Subcommittee put together a *South African ICD-10 Coding Standards* document to assist the South African healthcare industry with correct ICD-10 coding. This document is compiled from coding decisions made by the Technical Subcommittee and is constantly updated as required. This document should also be used for training purposes to ensure that coding in South Africa is standardised. Refer to the *South African ICD-10 Coding Standards* document (published on the website of the Council for Medical Schemes) for a complete set of the technical standards set by this Subcommittee. It is important to regularly check the website of the Council for Medical Schemes (www.medicalschemes.com) to ensure that the latest version of the document is used in the healthcare industry.

3.16. Official electronic BHF/DXS ICD-10 Master Industry Table

The official electronic BHF/DXS ICD-10 Master Industry Table (MIT), available from the Practice Code Number System division of the Board of Healthcare Funders (BHF), must be used as the basis of all ICD-10 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,
- the integrity of the ICD-10 system can be maintained and that maintenance of the system should be done at a central point, 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. Alternatively, the list should be used as an additional reference to the ICD-10 manuals to ensure that the codes used comply with the industry standards when submitted on claims.

The aim of this product (BHF/DXS ICD-10 Master Industry Table) is for everyone in the industry to use the same standard list/table of ICD-10 codes at the lowest possible cost.

BHF is handling the distribution and administration of the BHF/DXS ICD-10 Master Industry Table and need to keep a log of all users in the form of a registration form that must be completed by each user of the table when it is purchased. This is for BHF to comply with their World Health Organization licence agreement for the distribution of the ICD-10 information to the South African health care industry.

3.16.1. Updating of the official electronic BHF/DXS ICD-10 Master Industry Table (MIT)

The WHO periodically prints updated editions of the ICD-10 Volumes 1, 2 and 3 in order to include international corrigenda updates. The Task Team has implemented a process by which South Africa will include as many of these updates as possible in each update of the MIT. Because of the time of each of these events, you may find slight differences between the current MIT and the Volumes purchased through the WHO. Wherever possible, the Task Team will alert the health care industry to these differences when the WHO does release new ICD-10 Volumes. However, reference to the electronic MIT will again ensure that the latest standards are adhered to.

The MIT contains columns specifying whether changes to codes occurred, the start and end dates of changes and comments that provide information pertaining to that specific change.

There are three types of changes i.e.:

- Deleted ICD-10 codes
- Added ICD-10 codes
- Modified ICD-10 codes

Deleted ICD-10 codes:

Deleted ICD-10 codes are retained in the MIT; however these codes have been indicated as invalid in the "Valid_ICD10_ClinicalUse" column and an end date for use of this code will be indicated on the MIT. The use of these deleted codes may result in rejection of claims as medical schemes update their systems with the updated industry file. All the systems should regularly be updated with the latest version of the industry MIT file.

Added ICD-10 codes:

New ICD-10 codes are from time to time added to the ICD-10 diagnostic system and these new codes should be added to the systems. In some cases 3-character categories are being extended to include 4

and/or 5 character subcategories. Please ensure that you verify in the latest version of the MIT that you only use codes that are marked as valid codes. If a code is marked as invalid to the 4th character, then a 5th character must be added to ensure that only codes to their full specificity are used.

Modified ICD-10 codes:

Modified ICD-10 codes may include changes such as:

- Addition, changes or deletion of dagger and asterisk symbols
- Addition of 4th and/or 5th character codes
- Description changes
- Title changes

Short descriptions on the current MIT:

A column containing a short descriptor list exists in the current MIT. However, this short descriptor list should NOT be used since the requirement from the WHO is that where the descriptor is used, the full (complete) descriptor should always be used. In the future, this short descriptor list will be deleted from the MIT.

Please remember that no diagnosis descriptions should be included on claims. The reasons for this are two-fold:

- a. Maintenance of patient confidentiality, and
- b. In the electronic environment, each character in a description would be interpreted as a separate code.

(Refer to Circular 7 of 2008: *Changes to ICD-10 Master Industry Table*)

The BHF/DXS ICD-10 Master Industry Table (MIT) will be updated when necessary, to be implemented on 1 January each consecutive year. The current set of ICD-10 codes will at this stage be maintained until at least December 31, 2009. A final decision will be made during 2010 when to release the next updated version of the MIT.

Amendments to the current version of the ICD-10 Master Industry Table:

The following amendments will be made besides official corrigenda as published by the World Health Organisation:

- Fifth character validation on the Master Industry Table (MIT Revised M codes)
- Remove the short descriptions on the upcoming MIT update. (Review of Short descriptions on the MIT as per previously raised issues e.g. ICD-10 code M40.30 and M40.31 would then fall away).

- Possible WHO copyright infringement as raised by Karen regarding inconsistencies in the MIT descriptions, e.g. T84.6 and V48.00. Careful attention should be given when the MIT is updated to ensure that information on the MIT is the same as the electronic version of the WHO ICD-10.
- Plugging in ICD-0 Version 3, electronic version to be supplied by Pat from the Cancer registry. The books can be ordered from the WHO Press if the Cancer registry does not have the electronic version.
- All previous errata detected and mentioned in CMS Circulars after the implementation date of September 2007
- Incorrect descriptions on codes, removing the short description and allow the use of long descriptions only.

3.16.2. ICD-10 Manual: Version 2, 2005

The changes identified in Version 2 of the WHO Volumes, compared to Version 1, were included in the BHF/DXS ICD-10 Master Industry Table which was implemented on 1 September 2007. Effective to and from dates are indicated on the BHF/DXS ICD-10 Master Industry Table and all code changes (including added and deleted codes) were taken into consideration when the MIT was updated.

3.16.3. Validity of codes on the BHF/DXS ICD-10 Master Industry Table

On the BHF/DXS ICD-10 Master Industry Table (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 health care 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.

3.16.4. Inclusion of other diagnosis-related classifications

The viability of adding “plug-ins” to the ICD-10 schema, such as DSM-IV, ICD-O, ICD-DA, etc was discussed. Most of the plug-ins consists of the basic ICD-10 codes with extra characters (5th or 6th) for extra specificity. The addition of extra characters into the BHF/DXS ICD-10 Master Industry Table needs to be investigated. The standard electronic claim form has an identifier for different code sets and it was agreed that code fields should allow for ICD-10 codes up to 10 characters in length. National standards will have to change from 5-character codes as the maximum level of specificity if plug-ins is introduced. This however, is an issue that would require proper consultation before a final decision can be taken.

Recently the Committee decided to add the ICD-O version 3 “plug-in” code set to the next version of the MIT to assist with the correct diagnostic coding for the Cancer Registry. This code set will be available in the next version of the MIT still to be updated.

3.16.5. Links or guidelines for multiple condition coding

The BHF/DXS ICD-10 Master Industry Table does not contain links or guidelines for multiple condition coding. Such enhancements would be considered part of a value add in third party encoder software products, which require special licenses from the WHO.

3.16.6. Other ICD-10 electronic products on the market

There are currently a variety of electronic ICD-10 products on the market besides the BHF/DXS ICD-10 Master Industry Table. However, these products should be aligned with the only official version of electronic ICD-10 in South Africa, namely the electronic BHF/DXS ICD-10 Master Industry Table distributed by the Board of Healthcare Funders (BHF) to ensure standardisation of coding processes in the country. Please note that the electronic version of ICD-10 and also the electronic WHO book (which may be purchased under license agreement with the World Health Organisation) available from the WHO does not contain the ICD-10 unique codes to be used in South Africa.

3.16.7. Dagger codes not flagged to asterisk codes on the BHF/DXS ICD-10 Master Industry Table

Not all possible dagger codes are flagged to asterisk codes or with their asterisk combinations in the BHF/DXS ICD-10 Master Industry Table, as these need to be applied as is deemed clinically appropriate

for individual cases. Thus knowledge of the conventions of the volumes of ICD-10, as well as clinical knowledge is critical in appropriate allocation of dagger and asterisk combinations.

In the BHF/DXS ICD-10 Master Industry Table, only codes as per the ICD-10 volume 1 (Tabular Listing) were flagged as dagger codes, however, it does not necessarily mean that a non-flagged code cannot be used as a dagger code as per coding rules. Please note that the medical schemes should not reject ICD-10 codes used as dagger codes which are not flagged as dagger codes in the ICD-10 volume 1 or the BHF/DXS ICD-10 Master Industry Table.

3.17. Coding Definitions

3.17.1. Primary Diagnosis (PDX) – Morbidity

Please refer to the latest version of the South African ICD-10 Coding Standards document for the latest information regarding the definition of the primary diagnosis or main condition since this information has recently been updated.

3.17.2. Primary code

The primary code is the code that describes the primary 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 this is the condition that defines the primary code.

3.17.3. Secondary Diagnosis (SDX)

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
- Extended length of hospital stay; or
- Increased nursing care and/or monitoring
- Increased intensity of nursing care

External cause codes also fall under secondary diagnoses.

3.17.4. Secondary code

Secondary codes are codes that further describe the patient's condition or the cause of the patient encounter. Examples include diabetic retinopathy, motor vehicle accident (MVA), etc. The rules and conventions of ICD-10 coding as set out by the World Health Organisation (WHO) are applied to assign these codes appropriately.

3.17.5. Valid code

A valid code is an ICD-10 code that appears in the ICD-10 coding manuals according to the WHO rules and conventions and as specified in the BHF/DXS ICD-10 Master Industry Table. It comprises a primary code in the primary position on a claim. For multiple diagnoses, secondary codes are coded in the secondary position.

3.17.6. Co-morbid conditions

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

3.17.7. Complication

A complication usually arises subsequent to an existing condition, disease, pregnancy, injury, etc, or subsequent to treatment, procedures, and adverse reaction to drugs, chemicals, etc. A complication may become a primary diagnosis despite it not being the cause of admission.

Please take note when selecting codes in the Y40-Y84 range from the ICD-10 Volumes. These codes (used in the secondary position as they are external cause codes) are specifically to indicate the nature or origins of "Complications of medical and surgical care".

It is important to read the full description of these codes (including the section headings in the manuals) so that care is taken that these codes are not inappropriately indicated for services or treatments performed (refer to Circular 14 of 2007: *Communiqué: Common causes of ICD-10 related rejections or misinterpretations of appropriate code use.*)

3.17.8. Other coding definitions

Please refer to the latest version of the *South African ICD-10 Standards* document for definitions or information regarding the following and others:

- Current Injury vs. Old Injury
- Sequelae (late effect)
- 'Accidental', 'intentional', 'self harm' and 'undetermined intent'
- 'Uncertain' and 'unknown' when coding from the neoplasm table
- Neonate
- Difference between 'routine' examination and 'screening'
- 'Poisoning' (T36-T50) and 'adverse effect'

3.18. Consensus on 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. 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, the ".99" unspecified characters should 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 health care 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 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.

3.19. 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 health care providers are not allowed. By allowing different sets of rules and conventions the entire process is undermined and the consistency in application is compromised.

3.19.1. Specific coding requirements for symbols

Dagger and asterisk symbols:

Since not all computer programs support the original symbol used to indicate the dagger codes (†), it is recommended that coders use a plus sign. However, when using an electronic look-up or reference list containing ICD-10 codes, the dagger and asterisk symbols MUST be used to ascertain the correct combination codes that are required. In the electronic environment the plus sign (+) is used to indicate dagger codes and has been accepted as the standard symbol to be used instead of the (†) and (!) symbols.

Omitting the Dagger (+) and Asterisk (*) symbols is the agreed standard for both paper and electronic claims with the proviso that the sequence of the dagger and asterisk codes are maintained. Optionally, the dagger and asterisk symbols could be used when submitting paper claims but claims cannot be rejected based on whether the symbols are dropped or maintained in the paper claim environment.

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, are being retained and should always be reflected when codes with these symbols are used.

3.19.2. Digits versus characters

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).

3.19.3. 5th character mandatory versus optional use

Although the World Health Organisation (WHO) ICD-10 book (Volume 1: Tabular List) indicates that the use of a sub-classification, for example to indicate the site of involvement (5th character), is reflected for “optional” use, it was decided by the ICD-10 Task Team that all WHO rules and conventions were to be followed for South Africa and that the word “optional” be replaced with the word “mandatory”.

Chapters where the 5th character is required are as follows:

CHAPTER	CONTENTS	USE OF 5 TH CHARACTER
Chapter XIII	Diseases of the musculoskeletal system and connective tissue (M00-M99)	Subdivisions by anatomical site.
Chapter XIX	Injury, poisoning and certain other consequences of external causes (S00-T98)	Subdivisions to indicate open and closed fractures as well as intracranial, intra-thoracic and intra-abdominal injuries with or without open wound.
Chapter XX	External causes of morbidity and mortality (V01-Y98)	Subdivisions to indicate the type of activity being undertaken at the time of the event.
U codes unique to South Africa	Multi-drug resistant tuberculosis (MDR TB) (U50.-)	Type of drug for which the patient is resistant.

Please note that not all codes from the above chapters require coding up to a 5th character level. Some codes are valid at a 3 or 4 character level in these chapters. Follow the WHO coding rules and the SA ICD-10 Coding Standards for these chapters in order to code correctly.

3.19.4. Using the 'X'/'x' as a 4th character in 5th character-level coding

The use of the 'X' as a 4th character place holder in 5th character level codes where no 4th character is available, e.g. M45, is an international standard and local software vendors agreed to abide by this. Use of either an upper case 'X' or lower case 'x' in the place of the 4th character in codes

which do not have a valid 4th character, but must be specified to the 5th character for maximum specificity was investigated. Volume 2: Instruction Manual does not specify this standard, but it is printed as an upper case 'X'; the current standard as agreed upon by the Private Healthcare Information Standards Committee (PHISC) however is, that the 'x' is in the lower case. It was determined that the 'x'/'X' when used for this purpose must not be case sensitive.

Example:

M45 *Ankylosing spondylitis*

[Site code required which will be placed in the fifth character space]

M45.X9 *Ankylosing spondylitis, site unspecified*

Codes that require an 'X'/'x' in the fourth character position are:

M45.- *Ankylosing spondylitis*

T08.- *Fracture of spine, level unspecified*

T10.- *Fracture of upper limb, level unspecified*

T12.- *Fracture of lower limb, level unspecified*

V98.- *Other specified transport accidents*

V99.- *Unspecified transport accident*

3.19.5. Combination Codes

There are certain diseases or conditions that require two sets of codes to correctly or accurately describe a particular disease or condition. This is known as combination coding. The following are the four most common combination codes:

Sequelae codes

Late effects of a condition no longer present as a current illness. Initial condition must have occurred one or more years ago.

Example: Dysphagia due to stroke.

PDX: R13 *Dysphagia*

SDX: I69.4: *Sequelae of stroke, not specified as haemorrhage or infarction*

Note: The principal/primary diagnosis (PDX) is the late effect: *dysphagia* and the secondary diagnosis (SDX) is the initial or sequelae condition: *due to stroke*.

External cause codes to be used in addition to injury (S and T) codes

External cause codes permit the classification of environmental events, circumstances and conditions as the cause of injury, poisoning and other adverse effects. The South African standard is that all S and T codes are to be assigned together with the External Cause Codes, to their highest level of specificity. (Refer to chapter 19 of the ICD-10 books Volume 1: Tabular list.)

External cause codes are V, W, X, or Y codes

The PDX is the injury or poisoning code and the external cause code is the SDX.

Example: Open fracture neck of femur due to fall from tree, at home, whilst gardening.

PDX: S72.01: *Open fracture neck of femur*

SDX: W14.03: *Fall from tree, at home, whilst engaged in other types of work*

NOTE: The External Cause Code (ECC) section requires coding up to a 5th character level.

Dagger (+) and asterisk (*) codes

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

A dagger code (+) can be used on its own when there is no manifestation.

An asterisk code (*) can NEVER be used on its own or in the primary position. There are 83 special asterisk categories listed at the start of the relevant chapters in Volume 1: Tabular list of the ICD-10 books.

Example: Tuberculous peritonitis

PDX: A18.3+: *Tuberculosis of intestines, peritoneum and mesenteric glands*

SDX: K67.3*: *Tuberculous peritonitis*

- Notes:
1. The dagger (+) is the principal diagnosis (PDX) and the asterisk (*) is the secondary diagnosis (SDX).
 2. 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 manifestation are marked with the symbol (*) to indicate that these are asterisks codes.

Local infections

Coding of some infections require an additional code in order to identify the infecting organism(s).

Example: Acute cystitis due to E.coli infection

PDX: N30.0: *Acute cystitis*

SDX: B96.2: *Escherichia [E.coli] as cause of diseases classified to other chapters*

Note: The site of infection is coded as the primary diagnosis (PDX) and the infecting organism as the secondary diagnosis (SDX).

3.19.6. Clinically appropriate codes in the Musculoskeletal system and connective tissue section (M-codes)

A concern regarding the clinical inappropriateness of certain 5th character choices for the M-codes was raised. It was questioned whether there should be a South African standard for which 5th characters are appropriate for each M code. The conclusion was that all 5th characters should be maintained/allowed for use as is the World Health Organisation (WHO) standard. Audits should be conducted to track the inappropriate use of 5th character options and this should then be taken up as a training issue. However, the current BHF/DXS ICD-10 Master Industry Table only contains 5th character options within the M-section that make clinically appropriate sense (e.g. M65.34 - *Trigger finger, Hand*) in order to maintain the clinical integrity of the codes used. When the BHF/DXS ICD-10 Master Industry Table is next updated, all 5th character options within the M-section, even if the clinical integrity of the codes are not appropriate, would be added, however, inappropriate 5th character codes will be marked as invalid in the "Valid_ICD10_ClinicalUse" column.

3.19.7. Maternity codes that cannot be used as the primary diagnosis

The rules of ICD-10 pertaining to the maternity codes should be applied, namely, that codes from O80-O84 (delivery codes) should be used for primary morbidity coding only if no other condition classifiable to Chapter XV: *Pregnancy, childbirth and the puerperium* is recorded.

Maternity Z-codes that cannot be used in the primary position

The following Z codes may not be coded in the primary position as these must be used as additional information on the record of the mother who gave birth to indicate the birth outcome:

Z37.0 *Single live birth*

Z37.1 *Single stillbirth*

Z37.2 *Twins, both live born*

- Z37.3 *Twins, one live born and one stillborn*
- Z37.4 *Twins, both stillborn*
- Z37.5 *Other multiple births, all live born*
- Z37.6 *Other multiple births, some live born*
- Z37.7 *Other multiple births, all stillborn*
- Z37.9 *Outcome of delivery, unspecified*

3.19.8. "Sign and Symptom" codes (R00-R99)

Please refer to the latest version of the *South African ICD-10 Coding Standards* document the correct use of "sign and symptom" codes (R00-R99).

Please note that the sign and symptom codes, R codes, must be used as a last resort. It should also be noted that a 'diagnosis' may be a recording of a Sign and/or Symptom only, therefore the use of R codes are valid for use as primary diagnosis codes and should be recognised as such by medical schemes.

3.19.9. Coding for routine examinations

Refer to the latest version of the *South African ICD-10 Coding Standards* document for the list of codes to be used for routine examinations.'

3.19.10. Default codes

Refer to the latest version of the *South African ICD-10 Coding Standards* document information regarding default codes.

3.19.11. South African-specific U-codes

The following procedure needs to be followed if additional codes need to be added to the WHO ICD-10 structure: Identify the need; document it formally and refer it to the ICD-10 National Implementation Task Team; ICD-10 Task Team tables it for discussion; if accepted, standards will be set; and the decision will be communicated to the health care industry.

The following set of additional ICD-10 codes was developed, that are unique to South Africa, for use in the local healthcare environment. This was done in accordance with the WHO guidelines, and in consultation with the WHO.

Non-disclosure of clinical information

The following U-codes for non-disclosure were accepted by the WHO:

U98: *Non-disclosure*

U98.0: *Patient refusal to disclose clinical information*

U98.1: *Service provider refusal to disclose clinical information*

Please note that these above mentioned codes will be carefully profiled by medical schemes.

It should be noted that medical scheme entitlements are based on diagnosis and procedures which determine the appropriate level of reimbursement for each benefit. Thus if a patient or the health care provider fails to divulge diagnostic information, the scheme might sometimes not be able to determine whether the patient is entitled to the benefit being claimed for. The scheme will therefore have the right not to fund certain services for which diagnostic information is not divulged. Please note that if the above codes are used for a condition listed as a Prescribed Minimum Benefit, no benefits will be granted by the medical scheme since the condition was not divulged.

Code U98:1 *Service provider refusal to disclose clinical information* may never be used by pathologists as it is inappropriate for their purposes.

Code Z76.9 *Person encountering health services in unspecified circumstances* is the appropriate code for use by pathologists, radiologists and pharmacologists etc. in the absence of a referral diagnosis.

Drug resistant tuberculosis unique to South Africa

A situation unique to South Africa exists for which the WHO ICD-10 does not make provision and that is for the coding of drug resistant tuberculosis. A specific set of codes for this purpose was created and it was accepted by the WHO for use in South Africa.

Refer to the latest version of the *South African ICD-10 Coding Standards* document for the list of drug resistant tuberculosis codes unique to South Africa.

3.19.12. Coding standards for specific discipline groups

Refer to the latest version of the *South African ICD-10 Coding Standards* document for the list of coding standards for specific discipline groups.

3.19.13. Coding rules for P-codes

Please refer to the latest version of the *South African ICD-10 Standards* document for the coding rules for P-codes.

3.20. ICD-10 Quick Reference Code (QRC) lists

Accurate coding of diagnoses is important in order to

- describe health conditions accurately
- reimburse health care providers appropriately, and
- collect proper epidemiological data on health care patterns in South Africa.

For this reason, the use of Quick Reference Code (QRC) lists (shortened lists of ICD-10 codes) is not recommended. However, the ICD-10 Implementation Task Team is aware that there are many health care providers who are still using shortened lists of ICD-10 codes within their businesses and practices. This practice is strongly discouraged.

3.21. Submission of claims

The following are principle decisions made by the Committee in terms of the submission of claims:

- All health care providers, diagnosing and non-diagnosing, are required by law to provide diagnosis code(s) on all claims submitted to a medical scheme or provided to a member(s) for submission to a medical scheme for reimbursement.
- Supplying of diagnosis codes on accounts is not limited to health care providers in private practice but also includes persons rendering their own accounts for patients in the public sector.
- If the diagnosis of the first person treating the patient and that of the second person either treating the patient or doing special investigations differ, no one would be compromised since coding can be done by different sources/service providers at different stages/levels of care.
- All ICD-10 diagnostic coding will be performed as per the World Health Organisation's official rules and conventions. Specific deviations will be investigated if necessary and all such deviations will be published in the *South African ICD-10 Coding Standards* document.

- Matching the diagnosis and treatment should not become prescriptive in nature. It will be up to each individual medical scheme to profile health care providers using treatment that differs from the norm.
- In any situation in which a definitive diagnosis is not made, a Sign and/or Symptom code would be appropriate for use.
- South Africa is to stay with the ICD-10 diagnostic coding schema for the foreseeable future.

Claims rejections for invalid/incomplete ICD-10 codes

In order to be fully compliant with the legislation of the Medical Schemes Act, all medical schemes are now rejecting claims where ICD-10 codes are missing or incomplete, and are applying the rules of ICD-10 coding in the same consistent manner.

It has been noted that some health care providers are still submitting incomplete ICD-10 codes on claims, and that these codes are not valid according to the ICD-10 Master Industry Table (MIT). The claims are thus being rejected. Many of these claims include invalid 3 character codes. The reasons for these errors are varied, but include outdated software systems, lack of training, or health care provider disinterest.

It is incumbent upon every health care provider to ensure that he/she can provide ICD-10 codes which are valid and comply with the MIT. This MIT is contained within the BHF/DXS ICD-10 browser. (Refer to Circular 20 of 2007: *Communiqué: Claims rejections for invalid/incomplete ICD-10 codes*)

3.22. List of companies participating in the Technical subcommittee

The names of the persons representing the company have been omitted to ensure that when the representatives of companies change the participation of the companies are recognised.

REPRESENTING COMPANY	REPRESENTING COMPANY
Africode	Medikredit
Allied Health Professions Council SA (AHPCSA)	Medscheme Health Risk Solutions
Bankmed	Metropolitan Health Group (MHG)
Bayer Schering Healthcare Pharmaceuticals	Momentum Medical Scheme Administrators
Bedford Gardens Life - Accident & Emergency Unit	National Department of Health
BestMed	National Health Laboratory Service (NHLS)
Board of Healthcare Funders (BHF)	National Hospital Network
Careware	National Pathology Group
Chiropractic Association of SA (CASA)	Neil Harvey & Associates (NHA)
Clinix	Netcare

Code Medix	Paradigm Health
Community Pharmacist Sector of the PSSA (CPS)	Prime Cure
Corona Sub-Acute Hospital	Pro Med Computer Service
Council for Medical Schemes	Qualsa
Discovery Health	Rand Mutual
DXS	Resolution Health
e-MD	SA Dental Association (SASA)
GeoAxon	SA Medical Association (SAMA)
Ikat	SA Military Health Services
Krige & Partners Radiology SA	SA Private Practitioners Forum (SAPPF)
Lethimvula Healthcare (previous Old Mutual)	Sanlam Health
Liberty Health	Sechaba Medical Solutions
Life Healthcare	SITA
Managed Healthcare Systems (MHS)	SpesNet
MedCode Training and Consulting	Stats SA
Medcodelink	Status M A Admin
Med-e-Mass	Sub-Acute Hospital Association
Medi-Clinic	Switch
Medicover	Zieto
Medihelp	

4. REPORT OF THE TRAINING SUBCOMMITTEE

4.1. Terms of reference

The Training Subcommittee has been tasked with the following responsibilities:

- To develop minimum training standards for ICD-10
- These include standards around:
 - Training: NQF aligned
 - Training material: NQF aligned
 - Levels of training: basic, intermediate, advanced
 - Training of multiple coding systems-sub-sets
 - Certification
 - Trainer qualification / requirements
 - List of coding training companies and coding trainers

4.2. Shortcomings and challenges

- Clinical coding training is not yet a recognised course in South Africa and is not offered at Academic Institutions. There are no registered unit standards for ICD-10 training.
- Clinical coding training is in certain instances provided informally by training institutions and trainers - some of whom have had very little exposure to coding.
- There are very few internationally accredited professional coders in South Africa.
- Many persons responsible for capturing and assigning of codes are not clinically trained; some may have some clinical experience.
- There is no Clinical Coding Body or Association in South Africa to deal with coding issues and standards.
- It is difficult for companies and practices to take staff out of the work environment for a number of days and send them for training. This would impact negatively on their businesses.
- Training standards need to be in place as soon as possible as there are time constraints for the actual training.

Following discussions, it was decided that existing training and coding processes that are in place must not be discontinued as this will slow down the implementation process, if not halt it all together. This meant that trainers and companies that are providing coding training must continue to do so; however,

they must concurrently familiarise themselves with the documented standards and take appropriate steps in attaining appropriate knowledge, skills and qualifications.

Coders who are currently coding clinically trained or not, must continue to do so, however, they must concurrently take appropriate measures to attain the appropriate knowledge, skills and or qualifications. In light of the above, it was decided by members of the task team, that in setting minimum training standards, the training subcommittee must be sensitive to the above.

4.3. Macro objective of the Training subcommittee

- To have ICD-10 training standards for South Africa (SA) that is aligned to International Coding Training Standards and to the World Health Organisation (WHO) Training Standards.
- To have an ICD-10 training standards policy document for South Africa that all healthcare stakeholders can have access to.

4.4. Minimum recommended ICD-10 basic training standards

4.4.1. Morbidity Coding

This training will have two target groups and the minimum recommendations are as follows:

Target Group 1: Non-clinically trained personal

This training is aimed at nursing assistants and staff who have no clinical qualification or equivalent clinical experience

Course duration: 3 days (24 hours)

Day 1: Basic medical terminology and anatomy (Note: Medical terminology course must take place two to four weeks prior to the ICD-10 course)

Days 2 and 3: Basic ICD-10 training

Outcomes for the Introduction to ICD-10:

At the end of this training course, learners should have an understanding of or the ability to:

- Basic medical terminology
- Basic anatomy
- Background to ICD-10 internationally and in South Africa

- The legal requirements surrounding ICD-10 in South Africa
- The benefits and uses of ICD-10, especially in the South African Healthcare environment
- An introduction to mortality coding - to create an awareness of mortality coding
- The use of volumes 1 and 3 and introduction to volume 2
- Identify ICD-10 codes
- The use of ICD-10 codes at 3, 4 and 5th character levels
- The basic structure and principles of ICD-10 according to the WHO
- All the basic rules and conventions of ICD-10 according to the WHO
- To assign ICD-10 diagnostic codes up to a basic level - this involves code assignment for single conditions and the application of the combination coding rules
- To do discipline specific coding of single conditions and apply the combination coding rules
- Understand the definitions of principal, primary and secondary diagnoses and apply these in sequencing of codes

Target group 2: Clinically Trained Personnel

This course is aimed at Enrolled nurses, Registered Nurses, Medical Doctors and any other personnel who have clinical qualification or equivalent clinical experience in which they are competent with the application of basic medical terminology and anatomy.

Course duration: One day (8 hours)

Outcomes for the Introduction to ICD-10:

At the end of this training course, learners should have an understanding of or ability to:

- The background to ICD-10 internationally and in South Africa
- The legal requirements surrounding ICD-10 in South Africa
- The benefits and uses of ICD-10, especially in the South African Healthcare environment
- An introduction to mortality coding - to create an awareness of mortality coding
- The use of volumes 1 and 3 and introduction to volume 2
- Identify ICD-10 codes
- The use of ICD-10 codes at 3, 4 and 5th character levels
- The basic structure and principles of ICD-10 according to the World Health Organisation (WHO)
- All the basic rules and conventions of ICD-10 according to the WHO
- To assign ICD-10 diagnostic codes up to a basic level - this involves code assignment for single conditions and the application of the combination coding rules
- To do discipline specific coding of single conditions and apply the combination coding rules

- Understand the definitions of principal, primary and secondary diagnoses and apply these in sequencing of codes
- To assign ICD-10 codes for more complex medical cases and apply the sequencing rules accurately

Coders wishing to fully understand coding of complex cases, will however be required to attend the Intermediate and Advanced ICD-10 courses

4.4.2. Basic Mortality Coding

Pre-requisite:

Basic medical terminology and anatomy

Completion of the basic ICD-10 morbidity course

Target Group: This course is aimed at all health care providers who issue death certificates, Statistics South Africa, coders wishing to pursue coding as a career and Coding Trainers

Course duration: 8 hours

Outcomes for the course:

At the end of this training session, the health care provider should have an understanding of:

- The background to mortality coding internationally and locally
- The legal requirements surrounding mortality coding in South Africa
- Importance and uses of mortality coded data
- General uses of mortality coded data e.g. planning and evaluating health services and programs, medical and public health research, clinical education etc
- Specific uses of mortality coded data e.g. health situation and trend analysis, epidemiological surveillance, evaluation in health etc
- Users of mortality data e.g. Epidemiologists, Statisticians etc
- Sources of Mortality Data
- The rules and conventions of mortality coding
- The use of volumes 1, 2 and 3
- Applying the sequencing rules to mortality coding
- The concept of "underlying cause of death"
- Quality Assurance
- Use of the Mortality Data System Decision Tables to select the underlying cause of death

- Use of the mortality data system (currently in use for South Africa)

4.5. Training Material

- Must be outcomes based and NQF aligned as best as possible as currently there are no unit standards for ICD-10 training
- Trainer must apply the training cycle when developing materials
- The WHO Collaboration Centre has certain standards in place for ICD-10 training material that SA can adopt, if possible.

4.6. ICD-10 Complete Coding Course recommendations

4.6.1. Anatomy, Physiology and Medical Terminology (Non-medically trained staff)

Basic training standards have been set (24 hours currently), however learners will require more in-depth training that will include pathophysiology and some pharmacology.

Suggested hours of training: 144 hours of theory and summative assessments. 24 hours of facilitator based training and 120 hours of summative assessments (portfolio of evidence [POE]).

4.6.2. Introduction to Basic ICD-10 Training

Basic standards have been set for 8 hours. This is not sufficient as not enough practical applications are done during this period.

Suggested hours of training: 88 hours (8 hours of facilitator based training and 80 hours of summative assessment-to be done at the learners pace in his or her own time)

Please suggest unit standards as per the current standards set.

4.6.3. Intermediate ICD-10 Training

Suggested hours of training: 88 hours (32 hours of facilitator based training and 56 hours of summative assessment (POE) to be done at the learners pace in his or her own time)

Suggested Course Content

Understanding of all general notes, glossary descriptions, relational terms (everything that is not discussed in the basic course)

Combination Coding:

- Dagger and asterisk: complete use, including understanding of the three forms in which they appear
- Coding of infectious diseases that require additional codes
- Coding of neoplasms-functional activity and additional morphology code (not the complete training on ICD-O)

Coding of minor versus more significant conditions

Coding of comparative and contrasting diagnoses

Coding of several conditions that meet the criteria for primary diagnosis - intermediate level

Coding of acute versus chronic conditions

Coding of query, unknown and uncertain diagnoses

Coding of post procedural complications

Coding of poisoning and adverse reaction

Multiple coding guidelines

SA specific coding guidelines - refer learners to the technical standards document

Introduction to basic rules of all 21 chapters

4.6.4. Advanced ICD-10 Training

Suggestions

Course duration: 360 hours

Split into: 9 modules

Each module will entail 8 hours of facilitator based training and 32 hours of self-learning in the form of assignments/summative assessments.

There will be numerous unit standards within each module

Suggested Course Content

Module 1: Advanced coding rules of:

- Infectious and parasitic diseases
- Neoplasms, includes - ICD for oncology

Module 2: Advanced coding rules pertaining to:

- Diseases of the blood and blood-forming organs
- Endocrine, metabolic and nutritional disorders

Module 3: Advanced coding rules pertaining to:

- Mental and behavioural disorders
- Nervous system disorders

Module 4: Advanced coding rules pertaining to:

- Diseases of the eye and adnexa
- Diseases of the ear
- Diseases of the circulatory system

Module 5: Advanced coding rules pertaining to:

- Diseases of the respiratory system
- Diseases of the digestive system

Module 6: Advanced coding rules pertaining to:

- Diseases of the skin and subcutaneous tissue
- Diseases of the musculoskeletal system

Module 7: Advanced coding rules pertaining to:

- Genito-urinary system disorders
- Pregnancy, Childbirth and the puerperium

Module 8: Advanced coding rules pertaining to:

- Congenital and chromosomal disorders
- Conditions originating in the perinatal period
- The coding of signs, symptoms and abnormal clinical and laboratory findings

Module 9: Advanced coding rules pertaining to:

- The coding of injuries, poisoning and other consequences of external causes
- The external cause of injury coding rules
- Factors Influencing Health Status and contact with Health Services

SA-specific coding guidelines and legal implications to be covered in all levels of training, including all nine advanced modules as and when required

This means that non-clinically trained staff will require a minimum 672 hours of training to complete the ICD-10 course.

Clinically trained staff will require a minimum of 536 hours of training to complete the ICD-10 course - they must be pre-assessed in medical terminology, anatomy and physiology to get recognition for prior learning (RPL).

4.7. Assessment standards and criteria

The following assessment standards and criteria are applicable to the Basic Medical Terminology, Anatomy and Physiology and the Introduction to Basic ICD-10 Coding courses:

- Pre course assessment: to give recognition for prior learning - this must be a written assessment
- Mid-course assessment: either one or all of these: oral, written, practical exercises or observation.
- Post course assessment: written assessment

4.7.1. Assessment Criteria and Guidelines for the Medical Terminology, Anatomy and Physiology Course

Overall the assessment must include the recommendations below. A breakdown has been provided for the different levels of assessment

- 6 Assessment criteria that address Medical Terminology
- 6 Assessment criteria that addresses Anatomy
- 4 Assessment criteria that addresses Prefixes
- 4 Assessment criteria that address Suffixes
- 4 Assessment criteria that address Physiology
- 2 Assessment criteria per body system for practical exercises

Pre-assessment (Medical Terminology, Anatomy and Physiology)

(Non-Medical)

- 3 Medical terminology
- 3 Common medical abbreviations
- 2 Prefixes
- 2 Suffixes
- 2 Common combination terminology
- 3 Anatomy questions

Mid-Assessment

- Practical exercise, for example, Label a drawing of e.g. the human skeleton, an organ (Lung) etc
- List known conditions related to the diagram and explain or define conditions (address basic physiology)

Post-Assessment

- 3 Medical terminology
- 3 Common medical abbreviations
- 2 Prefixes
- 2 Suffixes
- 2 Common combination terminology
- 3 Anatomy questions

Summative Assessment (In a controlled environment)

(Post training, 2-4 weeks)

Questions can range from 25 - 50

- Practical questions to focus on terminology, anatomy, prefixes, suffixes and physiology

4.7.2. Assessment Criteria for the Introduction to Basic ICD-10 Coding Course

(Non-Medical)

- 2 Assessment criteria that addresses background and industry issues/legislation with regards to ICD-10
- 2 Assessment criteria that addresses uses and benefits of clinical coding
- 4 Assessment criteria that addresses rules and conventions of ICD-10 (theory)
- 4 Assessment criteria that address rules and conventions of ICD-10 (practical)
- 2 Assessment criteria per chapter for practical exercises, in other words there should be 2 practical exercises per chapter that equals 42 practical exercises in total that address the introductory course comprehensively.

Pre-Assessment (Introduction to Basic ICD-10 Coding)

(Non-Medical)

- 2 Industry related questions
- 2 Benefits of clinical coding
- 6 Questions on ICD-10 coding
- 3 Abbreviations used in ICD-10
- 2 Questions that address common coding errors

Mid-Assessment

- Observation on the use of Volume 1 and 3

- Observation on the understanding of a lead term
- Observation on assigning a code at a 3, 4 and 5th character level
- Code practical coding scenarios e.g. Pneumonia, Sinusitis (Acute vs. chronic), Tonsillitis, Abdominal pain, Hypertension, etc

Post-Assessment

- 2 Industry related questions
- 2 Benefits of clinical coding
- 6 Questions on the rules and conventions of ICD-10
- 2 Questions that address common coding errors
- 3 Practical examples

Summative Assessment

(Post training, within 2-4 weeks)

Questions can range from 42-50

An assessment will include:

- Practical scenarios to be coded using Volume 1 and 3
- Assessment to include the application of rules and conventions learnt
- Theoretical questions on the rules and conventions (definitions, types of combination codes etc)

4.7.3. Assessment Criteria for Introduction to Basic ICD-10 Coding (Clinically Trained persons)

- 4 Assessment criteria (AC) that address background and industry issues/legislation with regards to ICD-10
- 4 AC that addresses uses and benefits of clinical coding
- 6 AC that addresses rules and conventions of ICD-10 (theory)
- 6 AC that address rules and conventions of ICD-10 (practical)
- 2 AC per chapter for practical exercises, in other words there should be 2 practical exercises per chapter that equals 42 practical exercises in total that address the introductory course comprehensively. This can obviously be adjusted according to the target audience - if the training was done to a particular specialty group, and then the practical exercises should address that discipline and not all 21 chapters.

Pre-Assessment (Introduction to Basic ICD-10 Coding)

(Clinically trained)

- 2 Industry related questions
- 4 Benefits and uses of clinical coding
- 6 Questions on the rules and conventions of ICD-10
- 3 Questions that address common coding errors

Mid-assessment

- Observation on the use of Volume 1 and 3
- Observation on the understanding of a lead term
- Observation on assigning a code at a 3, 4 and 5th character level
- Observation on multiple coding
- Observation on combination coding
- Practical exercises e.g. Injuries with external cause code, poisoning, adverse reaction, neoplasms, pregnancy and childbirth, etc

Post-assessment

- 2 Industry related questions
- 2 Benefits and uses of clinical coding
- 6 Questions on the rules and conventions of ICD-10
- 2 Questions that address common coding errors
- 3 Practical examples

Summative Assessment

(Post Training, within 2-4 weeks)

Questions can range from 42 - 50

An assessment will include:

- Practical scenarios to be coded using Volume 1 and 3
- Assessment to include the application of rules and conventions learnt
- Theoretical questions on the rules and conventions (definitions, types of combination codes etc)

4.7.4. Assessment guideline to assess learners, in the absence of Unit Standards

0-49%: not yet competent

50-79%: partially competent

80-100%: competent

4.8. Certification

- An attendance certificate will be awarded for attendance at the Introduction to Basic ICD-10 coding course
- A completion certificate will be awarded on successful completion of all the assessments and once the learner has been deemed competent by the trainer/facilitator, for the Introduction to Basic ICD-10 coding course.
- All health care providers who qualify for Continued Professional Development (CPD) points will be awarded CPD points on completion of all the coding courses.

4.9. Pre-Course Study Guide

The members of the training-subcommittee working group decided that each learner needs a pre-course study guide in the form of a Medical Workbook for introduction to Medical Terminology, Anatomy and Physiology the following guidelines are to be used by trainers in development of the study guide:

4.9.1. Structure of the Medical Workbook

Common Medical Terminology

For example:

Appendicitis

Fracture

Common Medical Abbreviations

For example:

AIDS, DVT, UTI

Common Medical Prefixes

For example:

Angi/o (vessel)

Arteri/o (artery)

Common Medical Suffixes

For example:

- ectasis (stretching/dilation)
- ectomy (removal, excision)

Common Combination Terminology

For example:

- Hem/o/rrhage (bursting forth of blood)
- Retr/o/version (to turn back)

Common Anatomical Terminology

For example:

Positions, Sections, Regions

Anatomy and Physiology

(Structure around the 21 chapters of ICD-10)

For example:

- Chapter 1 (Certain infectious and parasitic diseases)
- A15 - Respiratory tuberculosis...
- Basic Anatomy of the lung
- Basic Physiology of the lung

4.10. Facilitator/Trainer Requirements (Standards)

4.10.1. Medical Terminology and Basic Anatomy Trainer

- A trainer must have:
 - a clinical qualification or equivalent clinical certification e.g., Nursing or Medical Degree or Diploma or a certification from a recognised institution in medical terminology and anatomy,
 - completed the unit standard "Plan and conduct assessment of learning". This is a SAQA requirement for 2004, and
 - An appropriate training qualification e.g. RAU or Damelin Train-the-Trainer, etc.

4.10.2. Clinical Coding Trainer

- A trainer must have:
 - a completion certificate in coding (ICD-10) up to an advanced level; or an international accreditation in clinical coding; or a recognized South African coding qualification (when unit standards are registered).
 - completed the unit standard "Plan and conduct assessment of learning". This is SAQA requirement as of 2004. (Ensure registration with the relevant authority),
 - an appropriate training qualification, and
 - trainers training the basic ICD-10 course do not need to have a clinical background; however when a trainer is training the Intermediate and Advanced ICD-10 courses, a clinical qualification or equivalent certification is necessary.

(Note: Internationally, all coders and coding trainers, in particular, have either a clinical background or formal training in anatomy, physiology and medical terminology, irrespective of level of course being trained or facilitated). In S.A. a basic coding trainer must have a clinical background or he /she must have completed 144 hours of anatomy, physiology and medical terminology or have an equivalent certification.

4.11. ICD-10 Trainers and Training companies in South Africa

4.11.1. Companies conducting external training

These are companies who provide training to external clients at a fee. They also provide training in anatomy, physiology and medical terminology.

- **Africode Consulting: Basic, intermediate and advanced**
 - 011 023 7677 / sithara@afrcode.co.za or info@afrcode.co.ca
- **Medcode Training and Consulting CC: Basic, intermediate and advanced**
 - 082 606 7757/ 082 570 1021 / elaines@medcodetraining.co.za, lynetc@medcodetraining.co.za
- **CodeMedix: Introduction to Basic ICD-10**
 - 021 930 9911 / www.codemedix.co.za

4.11.2. Companies conducting internal training

Companies and associations who provide in-house training to staff or members at no cost:

- **Discovery Institute: Basic and intermediate**

- 011 529 7015/3485 / dhinstitute@discovery.co.za
- **Life Healthcare: Basic and intermediate**
 - 011 219 9636 / Faith.barter@lifehealthcare.co.za
- **Mediclinic: Basic and intermediate**
 - 021 809 6500 / sunell.lubbe@mediclinic.co.za
- **Medihelp: Basic**
 - 012 334 2153 / mkruger@medihelp.co.za
- **MHG: Basic**
 - 021 480 4065 / vdiab@qualsa.co.za
- **Netcare: Basic and intermediate**
 - 011 482 4321 / Erna.VanRooyen@netcare.co.za
- **South African Dental Association**
 - 011 484 5288 / neilc@sada.co.za
- **Spesnet**
 - 012 683 0356 / lee@spesnet.co.za
- **State Information Technology Agency: Basic**
 - 083 376 7159 / annelise.vanwyk@sita.co.za

4.11.3 Criteria for coding training companies and trainers to be listed on the CMS website

Refer to Circular 26 of 2009.

5. REPORT OF THE CONFIDENTIALITY SUBCOMMITTEE

The initial feedback report from the Confidentiality subcommittee has been published separately on the Council for Medical Schemes website. Currently ongoing discussions are still taking place between the various stakeholders.

6. RECOMMENDATIONS OF THE NATIONAL ICD-10 TASK TEAM

The task team recommends that the following issues be taken forward in order to take the process of implementation of ICD-10 forward.

- Formation of a National Standards Body on Health Information that will assume responsibility for the continued implementation, management and review of ICD-10. The standards body will, among others, be responsible for the following:
 - establishment of a national help desk or advice centre to deal with all ICD-10 matters

- ensure that all relevant materials on ICD-10 are available in the country and accessible to stakeholders
- engage the WHO with a view to securing a single license for the country
- participate in the process to align legislative provisions on health/patient information from different sectors
- liaise with stakeholders on all matters pertaining to ICD-10
- review the status of non-diagnosing health care providers with regards to submission of ICD-10 codes
- update the industry BHF/DXS ICD-10 Master Industry Table regularly
- engage with the WHO on ICD-10 developments nationally, and internationally
- develop strategies for collection of ICD-10 codes by all stakeholders in the public and private sector, particularly those outside the medical schemes environment
- engage with SAQA and SETA to develop ICD-10 unit standards and/or engage with tertiary institutions to develop a curriculum for ICD-10 training
- assume responsibility for the accreditation of coding trainers and coding training companies
- assume responsibility for ICD-10 accreditation or certification
- update and enhance ICD-10 coding training and trainer standards
- critique coding tools and or products
- and implementation of clinical validation.