



South African ICD-10 Coding Standards

Developed to assist the clinical coder in the South African environment

The South African ICD-10 Coding Standards, Version 1.06 (as at September 2007)

Compiled by the National Task Team for the Implementation of ICD-10

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Acknowledgement

The South African Coding Standards (SACS) for ICD-10 coding in the South African environment have been agreed and compiled by the National Task Team (NTT) for the Implementation of ICD-10. Acknowledgment and thanks to the members of the NTT for their contribution and efforts in making this document possible.

Introduction

This document has been compiled with the aim of documenting all coding standards agreed on by the National Task Team.

The Council for Medical Schemes and the National Department of Health support the implementation of ICD-10 in the public and private health sector. This is a diagnostic coding standard that was adopted by the National Department of Health in 1996 and is now the responsibility of the National Health Information System of South Africa (NHISSA). It is a diagnostic coding standard that is accepted by all the parties as the coding standard of choice. [Reference – Final Document, ICD-10 implementation, August 2004]

Date Implemented – 1996

Coding Standards are:

1. Developed to assist the clinical coder.
2. Developed to keep a record and track implementation and changes.
3. To be used concurrently with the ICD-10 manuals and training material.

User Guide

A standard

- a specification by which something may be tested or measured (specification – details describing something to be done)
- the required level of quality

Example:

DSN1005 Coding Chest Infection

J22 Unspecified acute lower respiratory infection is accepted as the standard for coding “unspecified chest infection” when no indication of the affected chest part has been given. If it has been mentioned, code to the appropriate anatomical site.

A guideline

- a statement of principle giving general guidance

Example:

Z51.2 Other chemotherapy should not be used for the administration of chemotherapy for neoplasms.

Z51.1 Chemotherapy session for neoplasm should also be used for maintenance chemotherapy for neoplasms.

GSN0001

GSN – General Standard National

Covers General Standards for Diseases

0001 – A unique number allocated to the standard (the Standard Number)

DSN0101

DSN – Diagnosis Standard National

Covers Diagnosis Standards for Diseases, Health Related Problems and contact with Health Services

01 – The number **one** will indicate the ICD-10 chapter

01 – A unique number allocated to the standard (the Standard Number)

General Standard National (GSN)

GSN0001

GSN – **G**eneral **S**tandard **N**ational

Covers General Standards for Diseases

0001 – A unique number allocated to the standard (the Standard Number)

GSN0001 Primary Diagnosis

The primary diagnosis or main condition is defined as follows:

The main condition is defined as the condition, diagnosed at the end of the episode of healthcare, primarily responsible for the patient's need for treatment or investigation. It is the "main condition treated".

If there is more than one "main condition treated", then the condition held most responsible for the greatest use of resources should be selected.

Only in circumstances where there is more than one "main condition" and no information is available to determine which of the conditions is responsible for the greatest use of resources, the coder should revert to the default rule that allows selection of the first condition recorded by the responsible clinician.

If no diagnosis was made, the main symptom, abnormal finding or problem should be selected as the "main condition".

Episodes of healthcare or contact with health services are not restricted to the treatment or investigation of current illness or injury. Episodes may also occur when someone who may not currently be sick requires or receives limited care or services; the details of the relevant circumstances should be recorded as the "main condition".

Important Footnote

There can only be **one** Primary Diagnosis at the end of the episode of healthcare, primarily responsible for the patient's need for treatment or investigation.

Resources equates to money or overall financial costs. This includes Level of Acuity (LOA), Length of Stay (LOS), equipment, medication etc. as iterative parts of the patients treatment and care which would total up to "resource" use for the event or the episode of care.

[Reference – Minutes of the Technical Subcommittee meeting held on 05 August 2006, ICD-10 National Task Team]

GSN0002 Secondary Diagnosis/es

Secondary Diagnosis/es

The definition for other or secondary diagnosis is interpreted as additional conditions that affect patient care or may co-exist with the main condition in terms of requiring:

- 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 other or secondary diagnoses.

Sequencing Rule

Once the Primary Diagnosis has been established this should be followed by the other or secondary diagnosis, interpreted as additional conditions that affect patient care or conditions that co-exist with the primary diagnosis.

ICD-10 rules should be adhered to when sequencing these additional codes (secondary diagnosis codes) such as:

1. Primary Diagnosis
2. Rules in ICD-10
 - Dagger (+) and Asterisk (*) sequencing rule
 - External Cause Codes can never be in the primary position for morbidity coding

The SA ICD-10 Coding Standards are to be used concurrently with the ICD-10 volumes and training material.

- Sequelae Codes can never be in the primary position
 - Causative Organism Codes can never be in the primary position (B95 – B97)
 - Code in addition to rule as per ICD-10 notes
 - Multiple injury coding rule
 - Code symptom codes in addition to the underlying condition where appropriate
3. Assign final code from Volume 1 (Tabular List) making use of applicable rules and conventions

[Reference – Final Document, ICD-10 implementation, August 2004]

Co-morbidity

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

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

[Reference – Final Document, ICD-10 implementation, August 2004]

Complication

A complication usually arises subsequently to an existing condition, disease, pregnancy, injury, etc. or subsequent to treatment, procedures, adverse reaction to drugs and / or chemicals, etc.

A complication may become a principal diagnosis despite it not being the cause of admission.

[Reference – Final Document, ICD-10 implementation, August 2004]

GSN0003 ICD-10 Codes on Claims

An ICD-10 code must be stipulated by the practitioner on each line of service rendered on an account as flooding codes from the header to line level is problematic due to: possible differences in dates of service, different dependants, ability to identify Prescribed Minimum Benefits and conditions on the Chronic Disease List, etc.

At a header level (group 1) the ICD-10 code would be compulsory for hospitals. For doctor / practitioner claims, the header code (group 1) would be optional to indicate the referring doctor's code and the line level (group 3) would be mandatory conditional. While the population of the referring doctor's code at header level is not mandatory, the existence of the field is mandatory. The optional group 1 for doctors only refers to the ICD-10 code being optional, and does not refer to all the other details that should be included at a header level.

[Reference – Final Document, ICD-10 implementation, August 2004 and Circular no. 28 of 2007, Council for Medical Schemes]

GSN0004 Submission of claims

1. All health care providers (diagnosing and non diagnosing) are required by law to provide a diagnosis code on all claims submitted to a medical scheme or provided to a member for submission to a medical scheme.
2. If the diagnosis of the first person treating the patient and that of the second person either treating the patient or conducting special investigations differs, no one would be compromised since coding can be done by different sources and / or service providers at different stages and / or levels of care, and such coding may differ between practitioners, for a number of reasons.
3. Providing a diagnosis code on claims is not limited to health care providers in private practice (therefore persons rendering their own accounts) – refer to number 2 above. Practitioners working within the public health sector are also required to provide diagnosis codes.
4. All ICD-10 diagnostic coding will be performed as per the World Health Organisation's official rules and conventions.
5. Matching the diagnosis and treatment should not become prescriptive in nature. It will be up to each individual scheme to profile practitioners using treatment that differs from the norm.

The SA ICD-10 Coding Standards are to be used concurrently with the ICD-10 volumes and training material.

6. In any situation in which a definitive diagnosis is not made, a sign and / or symptom code would thus be appropriate for use.
7. South Africa will continue to use the ICD-10 diagnostic coding schema as the National Standard for the foreseeable future.

[Reference – Final Document, ICD-10 implementation, August 2004]

GSN0005 ICD-10 Subsets

ICD-10 as released by the WHO has been adopted for South Africa, with the morphology codes (ICD-10-O) being the only additional subset to be included in the initial implementation.

[Reference – Minutes of meeting held on 9 March 2005, ICD-10 National Task Team]

GSN0006 Level of Coding

ICD-10 codes will be used to the highest level of specificity for South Africa.

The specificity of codes is critical for collection of data; realizing that the collection of some specific fifth [5th] character information is difficult e.g. External Cause Codes (ECC) but most valuable to organizations like the Office of the Compensation Commissioner in terms of the Compensation for Injuries and Diseases Act (COIDA) and the Road Accident Fund (RAF) to manage their business and to investigate possible fraud. It is also of importance to medical schemes to determine the extent of their liability, which in most instances gets compensated by these entities particularly where patients involved are also members of medical schemes. Dropping the fourth [4th] and fifth [5th] characters for ECC is not an option and only where specific information is not available, the “.99” unspecified characters should be used in the fourth [4th] and fifth [5th] character positions.

[Reference – Final Document, ICD-10 implementation, August 2004]

Digit versus Characters

When referring to the ICD-10 code structure, the word “**character**” is the accepted standard terminology, i.e. codes will be referred to as three (3), four (4) or five (5) character codes and not digits.

The word “**digit**” has been replaced by the word “**character**” following the above agreement.

[Reference – Minutes of the Technical Subcommittee meeting held on 03 August 2005, ICD-10 National Task Team]

GSN0007 The use of U-codes

The following U codes for non-disclosure were reviewed by the WHO and found to be appropriate for our purpose.

U98 Non-disclosure

U98.0 Patient refusal to disclose clinical information

U98.1 Service Provider refusal to disclose clinical information

The above mentioned codes would have to be carefully profiled by funders.

Note:

The word “doctor” in U98.1 Doctor refusal to disclose clinical information was replaced by the word “service provider” following a request for the rewording of the South African specific U codes.

[Reference – Minutes of the Technical Subcommittee meeting held on 6 April 2005, ICD-10 National Task Team]

The SA ICD-10 Coding Standards are to be used concurrently with the ICD-10 volumes and training material.

It was noted that code **U98.1 Service Provider refusal to disclose clinical information** would 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.

[Reference – Minutes of the Technical Subcommittee meeting held on 15 February 2006, ICD-10 National Task Team]

GSN0008 Updating ICD-10 Codes

The current set of ICD-10 codes in the electronic version named the Master Industry Table (MIT) will be updated biennially on the 01st July to include WHO version updates. Updates may also take place if deemed necessary in the SA Healthcare environment, prior to the biennially update, should the situation warrant it.

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

GSN0009 The “X” in place of a fourth character

The use of the “X” as a fourth [4th] character in five [5] character level codes, where no fourth [4th] character is available is an International standard which has been adopted and agreed on by local software vendors.

Example 1:

M45 – Ankylosing spondylitis

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

M45.X9 – Ankylosing spondylitis, site unspecified

Example 2:

T08 – Fracture of spine, level unspecified

[The fifth character will denote open or closed]

T08.X0 – Fracture of spine, level unspecified, closed

The fourth [4th] character is replaced by either a capital (upper case) “X” or small (lower case) “x” where codes do not have a valid fourth [4th] character but require a fifth [5th] character.

[Reference – Final Document, ICD-10 implementation, August 2004]

Codes that require a “X” or “x” in the fourth character position are:

M45

T08

T10

T12

V98

V99

GSN0010 Dagger and Asterisk Symbols

Dropping of the dagger (+) and asterisk (*) symbols is the agreed standard for the electronic environment. The sequence of the dagger and asterisk codes must be maintained.

[Reference – Final Document, ICD-10 implementation, August 2004]

The use of the dagger (+) and asterisk (*) symbols in the paper claim environment is not mandatory. The sequence of the dagger and asterisk codes must be maintained if the symbols are dropped. Claims should not be rejected based on whether the symbols are dropped or maintained in the paper claim environment.

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

GSN0011 Inappropriate use of fifth [5th] character options

Clinically appropriate fifth [5th] character codes should be used as the inappropriate use of fifth [5th] character codes will result in rejections.

Example 1:

M65.34 – Trigger finger, hand

In this instance, the option for the fifth [5th] character should only be 4 and not one of the others

0 – Multiple sites

1 – Shoulder region

2 – Upper arm

3 – Forearm

4 – Hand

5 – Pelvic region and thigh

6 – Lower leg

7 – Ankle and foot

8 – Other site

9 – Unspecified site

Some codes may not be taken to the fifth character code as they should be classified elsewhere.

Example:

M71.56 is not on the MIT. M71.5 Other bursitis, not elsewhere classified. This condition can be classified to M70.56 Other bursitis of knee, Lower leg.

[Reference – Final Document, ICD-10 implementation, August 2004 and Circular no. 14 of 2007, Council for Medical Schemes]

GSN0012 Appropriate codes to be used together with medical practitioner service codes for the completion of forms, scripts and motivations

The ICD-10 code for the condition(s) should be used for:

- the completion of a chronic medication form
- the writing of a repeat script or the request for a routine pre-authorisation
- the writing of special motivations for procedures and treatment

Medical practitioner service code and description:

0199 Completion of **chronic medication** forms by medical practitioners with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent

0132 Consulting service e.g. writing of repeat scripts or requesting routine pre-authorisation without the physical presence of the patient (needs not be face-to-face contact) (“Consultation” via SMS or electronic media included)

0133 Writing of special motivations for procedures and treatment without the physical presence of a patient (includes report on the clinical condition of a patient) requested by or on behalf of a third party funder or its agent

[Reference – Working Group Meeting held on 17 July 2007, ICD-10 National Task Team]

GSN0013 Coding of Syndromes

A syndrome is a collective group or set of symptoms typical of a distinctive disease or frequently occurring together.

Guideline

When coding a syndrome establish the collective group or set of symptoms or related conditions and code these individually, sequencing the main condition treated first [as per SA primary diagnosis] and any other conditions that affect patient care or co-exist with the main condition in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring [as per SA secondary / additional diagnosis].

Example:

"Metabolic syndrome" referred to as: "Syndrome X" or "Insulin resistance syndrome" or "Dysmetabolic syndrome X" or "Reaven syndrome"

Metabolic syndrome is a constellation of conditions that place people at high risk for coronary artery disease. These conditions include type 2 diabetes, obesity, high blood pressure, and a poor lipid profile with elevated LDL ("bad") cholesterol, low HDL ("good") cholesterol, elevated triglycerides. All of these conditions are associated with high blood insulin levels. The fundamental defect in the metabolic syndrome is insulin resistance in both adipose tissue and muscle. Drugs that decrease insulin resistance also usually lower blood pressure and improve the lipid profile.

The term Reaven syndrome refers to the Stanford University physician Gerald Reaven who first described the syndrome at the 1988 Banting Lecture of the annual meeting of the American Diabetes Association."

Metabolic syndrome recorded on patient's medical record. Patient has hypertension, dyslipidaemia, insulin resistance and is obese. Known type II diabetic.

PDX: I10 Essential (primary) hypertension

SDX: E78.5 Hyperlipidaemia, unspecified

SDX: E66.9 Obesity, unspecified

SDX: E11.9 Non-insulin-dependent diabetes mellitus without complications

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

GSN0014 Updating of the SA ICD-10 Coding Standards Document

The coding standards will be updated once a final decision has been reached.

A summary of changes will be compiled and included in the SA coding standards document after each update.

A three month period will be allowed for the implementation of the change.

The latest version of the SA ICD-10 Coding Standards document available on the Council for Medical Schemes website must be referenced and used together with the ICD-10 volumes or the latest MIT when coding and / or facilitating a coding course in the medical and or health insurance environment of SA.

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

GSN0015 Sequelae (Late Effects)

Sequelae codes are used to indicate conditions that are no longer present but are the cause of a current problem now under treatment. Terms such as “old”, “no longer present”, “late effect”, or those present 1 year or more after onset of the casual condition may be used to indicate a sequelae condition.

Guideline

Refer to the note below the three character code in the Tabular List (Volume 1) when assigning a sequelae code.

Example:

Note at I69

This category is to be used to indicate conditions in I60 – I67 as the cause of sequelae, themselves classified elsewhere. The “sequelae” include conditions specified as such or as late effects, or those present one year or more after onset of the casual condition.

Rules on assignment

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

[Reference – Final Document, ICD-10 implementation, August 2004 and Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

Diagnosis Standard National

DSN0101

DSN – **D**iagnosis **S**tandard **N**ational

Covers Diagnosis Standards for Diseases, Health Related Problems and contact with Health Services

01 – The number **one** will indicate the ICD-10 chapter

01 – A unique number allocated to the standard (the Standard Number)

DSN01 Certain infectious and parasitic diseases (A00 – B99)

DSN02 Neoplasms (C00 – D48)

DSN03 Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50 – D89)

DSN04 Endocrine, nutritional and metabolic diseases (E00 – E90)

DSN05 Mental and behavioural disorders (F00 – F99)

DSN06 Diseases of the nervous system (G00 – G99)

DSN07 Diseases of the eye and adnexa (H00 – H59)

DSN08 Diseases of the ear and mastoid process (H60 – H95)

DSN09 Diseases of the circulatory system (I00 – I99)

DSN10 Diseases of the respiratory system (J00 – J99)

DSN11 Diseases of the digestive system (K00 – K93)

DSN12 Diseases of the skin and subcutaneous tissue (L00 – L99)

DSN13 Diseases of the musculoskeletal system and connective tissue (M00 – M99)

DSN14 Diseases of the genitourinary system (N00 – N99)

DSN15 Diseases of Pregnancy, Childbirth and the Puerperium (O00 – O99)

DSN16 Certain conditions originating in the perinatal period (P00 – P96)

DSN17 Congenital malformations, deformations and chromosomal abnormalities (Q00 – Q99)

DSN18 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00 – R99)

DSN19 Injury, poisoning and certain other consequences of external causes (S00 – T98)

DSN20 External causes of morbidity and mortality (V01 – Y98)

DSN21 Factors influencing health status and contact with health services (Z00 – Z99)

DSN22 Codes for special purposes (U00 – U99)

Diagnosis Standard National – 01

Certain infectious and parasitic diseases (A00 – B99)

DSN0101 HIV / AIDS

Human Immunodeficiency Virus (HIV)

H – Human because the virus causes disease in human beings.

I – Immune because the virus attacks and damages the human immune system.

V – Virus (a Virus is an infectious agent that needs to live inside a cell in order to survive). This virus utilizes the cells of the immune system and consequently destroys these cells.

Acquired Immune Deficiency Syndrome (AIDS)

AIDS is a collection of specific illnesses and conditions which occur because the body's immune system has been damaged by HIV.

A – Acquired because it is a condition that one can acquire or get infected with, not something transmitted through the genes.

I – Immune because it affects the body's immune system (the part of the body which usually works to fight off germs such as bacteria and viruses).

D – Deficiency because it makes the immune system deficient (makes it not work properly).

S – Syndrome because it is a collection of signs and symptoms that together comprise a medical diagnosis.

Definition of AIDS

1. Antibody test for HIV is positive (i.e. Elisa test or Western Blot test).
2. Development of AIDS defining medical diseases e.g. disseminated tuberculosis (TB), cryptococcal meningitis, Kaposi's sarcoma etc.
3. Failing immune system: a CD4 count <200 cells/cu mm or CD4 percentage below 15% in adults.

NB – note that the definition in children does not require a specific CD4 number or %.

However, it is unusual to have AIDS in children with a % greater than 25.

Coding standard for B20

B20 Human immunodeficiency virus [HIV] disease resulting in infectious and parasitic diseases

B20.0 – B20.8

- The HIV code B20.– is sequenced first (in the primary position).
- The code for the resultant infectious and / or parasitic disease is coded in the secondary position as this adds specificity.

Example:

HIV resulting in tuberculosis

PDX: B20.0 HIV disease resulting in mycobacterial infection

SDX: A16.9 Respiratory tuberculosis unspecified, without mention of bacteriological or histological confirmation

Coding Guideline

B20.6 HIV disease resulting in Pneumocystis carinii pneumonia

- B20.6 code can be used alone when coding HIV resulting in pneumocystis carinii pneumonia as the code description fully describes the condition.

B20.7 HIV disease resulting in multiple infections

- Sequence the individual HIV code in the primary position.
- Code the multiple infections individually if you have the detailed information. Each infection must be coded separately according to the South African standard where multiple coding has been agreed on. The codes for the multiple infections will add specificity.

Example:

HIV resulting in severe bacterial pneumonia due to E-coli and oesophagitis

PDX: B20.7 HIV disease resulting in multiple infections

SDX: J15.5 Pneumonia due to Escherichia coli

SDX: K20 Oesophagitis

The SA ICD-10 Coding Standards are to be used concurrently with the ICD-10 volumes and training material.

B20.9 HIV disease resulting in unspecified infectious or parasitic disease

- This code can be used alone when the infectious and / or parasitic disease has not been specified

Coding standard for B21

B21 Human immunodeficiency virus [HIV] disease resulting in malignant neoplasms

B21.0 – B21.8

- The HIV code B21.– is sequenced first (in the primary position).
- The code for the resultant malignant neoplasm is coded in the secondary position as this adds specificity.

Example:

HIV resulting in Kaposi's sarcoma

PDX: B21.0 HIV disease resulting in Kaposi's sarcoma

SDX: C46.9 Kaposi's sarcoma, unspecified

SDX: M9140/3 Kaposi's sarcoma, primary site

Coding guideline – Kaposi's Sarcoma

- The Physician must indicate a clear link between the HIV and Kaposi's sarcoma.
- Coders must not assume that the Kaposi's sarcoma is due to / as a result of HIV.

NB This will apply to all the possible manifestations

B21.7 HIV disease resulting in multiple malignant neoplasms

- Sequence the individual HIV code in the primary position.
- Code the multiple neoplasms individually if you have the detailed information. Each neoplasm must be coded separately according to the South African standard where multiple coding has been agreed upon. The codes for the multiple neoplasms will add specificity.

Coding Guideline

B21.9 HIV disease resulting in unspecified malignant neoplasm

- This code can be used alone when the malignant neoplasm has not been specified

Coding standard for B22

B22 Human immunodeficiency virus [HIV] disease resulting in other specified diseases

This range of codes is used for HIV resulting in other specified diseases

B22.7 HIV disease resulting in multiple diseases classified elsewhere

- This code should generally not be used according to the South African standard. Each condition must be coded individually.

Coding Guideline from Volume 2

Please note that volume 2, ICD-10, First Edition, page 113, indicates that B22.7 should be used when conditions classifiable to two or more categories from B20-B22 are present.

This will therefore not apply as the SA standard is to code each condition individually.

Coding standard for B23

B23 Human immunodeficiency virus [HIV] disease resulting in other conditions

B23.0 Acute HIV infection syndrome

- This code can only be used once in a patient's life time. This code cannot be used again once the patient has recovered from the primary illness.

Acute HIV Infection Syndrome

Acute HIV Infection Syndrome (a medical condition) is the onset of an acute illness arising from or following the first exposure of the person to the HIV virus.

This is characterized by fever, fatigue, enlargement of lymph glands, a skin rash and a general feeling of being unwell. It usually occurs within 2 – 6 weeks after exposure (sexual, mother to child or blood products) and will last for approximately 4 weeks. Not every exposed individual will experience this syndrome. In addition, the antibody blood tests for HIV are negative (i.e. the Elisa or Western blot). This is the so called “window period”. The viral blood count (viral load) is very high during this time and the individual is extremely infectious to other sexual partners.

The diagnosis is confirmed by obtaining a positive antibody test over time (Elisa test) i.e. the patient “sero-converts”. This usually occurs within 6 – 12 weeks after acquiring the infection.

During the period that the Elisa test is negative, the infection can be confirmed with either a positive p24 antigen test and / or a positive viral load test (HIV PCR).

Acute infection with HIV only occurs once in the patient’s life time.

Synonyms for Acute HIV Infection Syndrome are:

- Primary HIV infection
- Acute Seroconversion Syndrome

Example:

Patient presents with lymphadenopathy and a generalized skin rash with a complication of meningitis. The final diagnosis made is acute HIV infection syndrome.

PDX: B23.0 Acute HIV infection syndrome

SDX: G03.9 Meningitis, unspecified

SDX: R59.1 Generalized enlarged lymph nodes

SDX: R21 Rash and other nonspecific skin eruption

B23.2 HIV disease resulting in hematological and immunological abnormalities, not elsewhere classified

- This code indicates that the HIV disease resulted in hematological and immunological abnormalities.
- The hematological and immunological abnormalities are not as a result of and / or due to drugs and / or medication taken to treat the HIV disease.

Examples of hematological and immunological abnormalities:

- Anaemia
- ITP - Idiopathic Thrombocytopaenic Purpura
- TTP – Thrombotic Thrombocytopaenic Purpura
- Vasculitis etc.

Example 1:

Patient presents with idiopathic thrombocytopenic purpura due to his HIV disease

PDX: B23.2 HIV disease resulting in haematological and immunological abnormalities, not elsewhere classified

SDX: D69.3 Idiopathic thrombocytopenic purpura

Example 2:

A patient is admitted with anemia resulting from AIDS

PDX: B23.2+ HIV disease resulting in haematological and immunological abnormalities, not elsewhere classified

SDX: D63.8* Anaemia in other chronic diseases classified elsewhere

B23.8 HIV disease resulting in other specified conditions

- This code is to be used to indicate HIV disease resulting in other specified conditions that are not mentioned in category B20 – B22.

B24 Unspecified human immunodeficiency virus [HIV] disease

- This code is to be used for a HIV infected individual with symptomatic conditions caused by the HIV infection but the associated symptoms or conditions are not specified and cannot be assigned to B20 – B23.

Example 1:

Patient has AIDS and presents with weight loss, fever, and malaise.

PDX: B24 Unspecified human immunodeficiency virus [HIV] disease

SDX: R63.4 Abnormal weight loss

SDX: R50.9 Fever, unspecified

SDX: R53 Malaise and fatigue

Coding Guideline

It is not mandatory to code the symptoms as they are inherent in AIDS. The symptom codes are permissible to use as they will give additional information.

Example 2:

A patient is admitted for a cholecystectomy for chronic cholecystitis.

He presents with oesophagitis and is known to have AIDS. There is no documented link between the oesophagitis and the AIDS.

PDX: K81.1 Chronic cholecystitis

SDX: K20 Oesophagitis

SDX: B24 Unspecified human immunodeficiency virus [HIV] disease

Example 3:

A patient with AIDS is admitted with drug-induced haemolytic anemia from an antiretroviral drug which he is taking as prescribed.

PDX: D59.2 Drug-induced nonautoimmune haemolytic anaemia

SDX: Y41.5 Adverse effects in therapeutic use: antiviral drugs

SDX: B24 Unspecified Human Immunodeficiency Virus [HIV] disease

Aids Related Complex (ARC)

This is an absolute term initially used in the 1980's and 1990's for patients with skin rashes, herpes zoster (shingles), oral thrush etc., but who did not have full blown AIDS defining conditions (Not an opportunistic disease).

The term implies progressive HIV related infection and the likelihood of developing AIDS usually within an 18 month time period.

R75 Laboratory evidence of human immunodeficiency virus [HIV]

This code relates to patients who have an inconclusive HIV test.

Use this code for:

- Non-conclusive HIV test findings in infants.
- False positive tests in adults.

Z11.4 Special screening examination for human immunodeficiency virus [HIV]

- Used for screening purposes e.g. Elisa test

Z20.6 Contact with and exposure to human immunodeficiency virus [HIV]

- Used to indicate that the patient has been exposed to HIV e.g. blood products

Z21 Asymptomatic human immunodeficiency virus [HIV] infection status

- Used when a patient has a positive HIV status but asymptomatic i.e. has no active HIV AIDS disease.
- Positive HIV infection status with an illness that is unrelated to the **HIV status**.

Coding Rule for Z21

This code will never be assigned as the primary diagnosis.

Example:

Dental caries in a HIV positive patient

PDX: K02.9 Dental caries, unspecified

SDX: Z21 Asymptomatic human immunodeficiency virus [HIV] infection status

HIV Sequencing Rules

If the main condition treated is the HIV use the appropriate code from B20 – B24.

The clinical notes / records indicate that the condition is as a result of the HIV disease

Example:

HIV resulting in candidiasis of the mouth – code as follows:

PDX: B20.4 HIV disease resulting in candidiasis

SDX: B37.0 Candidal stomatitis

If the patient is HIV positive and there is no indication in the clinical notes / records that the condition is as a result of the HIV then code as follows:

Example:

Patient presents with candidiasis of the mouth. Patient is HIV positive.

PDX: B37.0 Candidal stomatitis

SDX: Z21 Asymptomatic human immunodeficiency virus [HIV] infection status

[Reference – Working Group Meeting held on 17 July 2007, ICD-10 National Task Team]

DSN0102 Coding prophylactic administration of anti-malaria drugs

Z29.8 Other specified prophylactic measures should be used for the prophylactic administration of anti-malaria drugs

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

Diagnosis Standard National – 02

Neoplasms (C00 – D48)

DSN0201 Neoplasm Coding

Neoplasm

Tumour, any new and abnormal growth, specifically one in which cell multiplication is uncontrolled and progressive. Neoplasms may be benign or malignant.

Malignant

Having the properties of anaplasia, invasiveness and metastasis said of tumours.

Metastasis

Transfer of disease from one organ or part of the body to another not directly connected with it due either to transfer of pathogenic micro-organisms or to transfer of cells. All malignant tumours are capable of metastasising.

Cancer

Any malignant, cellular tumour. Cancers are divided into two broad categories – carcinoma and sarcoma.

Carcinoma

A malignant new growth made up of epithelial cells tending to infiltrate surrounding tissues and to give rise to metastases.

Sarcoma

A malignant tumour of mesenchymal derivation.

Cellular Morphology

In neoplasms, it refers to the study of the form and structure of the neoplastic cells, or the histopathology of the cells.

Note

There are two types of codes involved in neoplasm coding

- Codes from Chapter II – Neoplasms (C00 – D48)
- Additional Morphology codes that identify the histological type and behaviour of the neoplasm (listed in the Tabular List, Volume 1)

Morphology codes

- The use of morphology codes is currently not mandatory
- Coders are encouraged to make use of these codes
- The behaviour of the neoplasm can be changed to suit the diagnosis

Guideline

Morphology codes are recommended for use together with the diagnostic code as optional and not mandatory in the South African environment until the mandatory requirement has been stipulated.

In-situ malignancies

Neoplasms that have the potential for local invasion but remain limited and have not extended beyond the basement membrane of the epithelial tissue.

In-situ malignancies are non-invasive and do not metastasise.

Note:

Carcinoma in situ is a specific diagnosis that will be made by a pathologist.

“Microinvasion” is the microscopic extension of malignant cells into adjacent tissue in carcinoma in situ.

Carcinoma in situ reported with any evidence of **micro-invasion** should be coded as malignant.

Primary Malignancy

Identifies the site of origin of the tumour e.g. breast

Do not confuse the definition of a **primary malignancy** with that of a **primary diagnosis**.

Important note:

Once determined (e.g. pathology report), the primary site will remain the same regardless of whether there are metastases and treatment occurs elsewhere in the body.

There is the possibility of a patient having more than one primary site.

If a patient has more than one primary malignancy then each primary should be coded separately.

Guideline:

Malignant, Primary

A malignancy is coded as primary when:

- It is specified as primary
- There is no other evidence to suggest that it is not primary
- Default to primary when you do not have sufficient information

Therefore if the neoplasm table does not have an entry in the malignant primary or in-situ columns e.g. lymph nodes, code as indicated.

Example 1:

Malignancy of the breast

PDX: C50.9 Malignant neoplasm, breast, unspecified

M8000/3 Neoplasm, malignant, primary site

Note:

Behaviour code /3 indicates the malignant neoplasm is stated or presumed to be primary

Example 2:

Primary malignancy of the eye and primary malignancy of the breast

PDX: C69.9 Malignant neoplasm, eye, unspecified

M8000/3 Neoplasm, malignant, primary site

SDX: C50.9 Malignant neoplasm, breast, unspecified

M8000/3 Neoplasm, malignant, primary site

Guideline:

The definition of the primary diagnosis must be adhered to. If no further information is available in terms of which malignancy to code as the primary diagnosis, code the condition listed first as the primary diagnosis.

C97 Malignant neoplasms of independent (primary) multiple sites

Volume 2 indicates that **C97** should be used when the health practitioner records as the main condition two or more independent primary malignant neoplasms, none of which predominates. Additional codes may be used to identify the individual malignant neoplasms listed".

- This rule is not applicable for SA use.
- Each condition must be recorded independently.
- The code C97 should not be used unless no further information is available.

Example:

Multiple carcinomas

PDX: C97 Malignant neoplasms of independent (primary) multiple sites

M8000/3 Neoplasm, malignant, primary site

Secondary Malignancy

A secondary malignancy is the site to which the primary tumour has metastasised. The new growth is secondary to the primary site.

Terms such as "**metastasis (mets)**" or "**spread**" refer to a secondary malignant neoplasm.

Rule:

Secondary malignancies should be coded in addition to the primary malignancy.

A secondary malignancy will be sequenced as a primary diagnosis if the main condition being treated is the secondary neoplasm.

Example:

Patient admitted for treatment of lung cancer which has spread from the breast.

PDX: C78.0 Secondary malignant neoplasm of lung

M8000/6 Neoplasm, malignant, metastatic site

SDX: C50.9 Malignant neoplasm, breast, unspecified

M8000/3 Neoplasm, malignant, primary site

Note:

Behaviour code /6 indicates the malignant neoplasm is stated or presumed to be secondary

Malignant neoplasm without specification of site

C80 Malignant neoplasm without specification of site is used with specific secondary codes to indicate an unknown primary malignancy. The behaviour code at the end of the morphology code will indicate primary or secondary.

If the site of the secondary and or tissue type is unknown, the code C80 Malignant neoplasm without specification of site should be used in addition to the code for the primary malignancy.

When cancer is simply described as “metastatic” with no further information about the morphological type, but a site is mentioned, code to malignant primary of the given site with C80 as an additional code to identify secondary malignancy of an unknown site.

Exception to the above

“See Common Sites of Metastases”

Guideline:

A secondary neoplasm can never appear on its own without a point of origin.

Example 1:

Primary malignancy of the breast with metastasis

PDX: C50.9 Malignant neoplasm, breast, unspecified

M8000/3 Neoplasm, malignant, primary site

SDX: C80 Malignant neoplasm without specification of site

M8000/6 Neoplasm, malignant, metastatic site

Example 2:

Metastatic cancer of the pleura

PDX: C80 Malignant neoplasm without specification of site

M8000/3 Neoplasm, malignant, primary site

SDX: C78.2 Secondary malignant neoplasm of pleura

M8000/6 Neoplasm, malignant, metastatic site

Coding of “generalized” or “disseminated” cancer (malignancy) or “carcinomatosis without further site specification”

When the diagnosis is given as “generalized” or “disseminated” cancer (malignancy) or carcinomatosis without further site specification, the code C80 is used. In this case the C80 represents all of the malignancy – unknown primary and unknown secondaries.

Note:

This should not be coded if specific information with regard to site(s) can be found in the source documentation or records.

Example:

Patient is diagnosed as having carcinomatosis

PDX: C80 Malignant neoplasm without specification of site

M8000/6 Neoplasm, malignant, metastatic site

SDX: C80 Malignant neoplasm without specification of site

M8000/3 Neoplasm, malignant, primary site

Common Sites of Metastases

There are a number of sites that are likely to be secondary or commonly secondary.

Therefore a statement of "metastatic" qualified by one of the following sites should be coded to malignant secondary of the given site, with C80 as an additional code to identify primary malignancy of unknown site.

These will be regarded as secondary in the indicated instances as discussed above:

- Bone
- Brain
- Diaphragm
- Heart
- Liver
- Lung
- Lymph nodes
- Mediastinum
- Meninges
- Peritoneum
- Pleura
- Retroperitoneum
- Spinal Cord
- Ill-defined sites (sites classifiable to C76.–)

Reference ICD-10, Volume 2, First Edition, page 76

Exceptions to the rule

If the primary and secondary are both present, then the primary will normally be sequenced first. However, given the standard definition for the primary diagnosis for coding purposes, this will not always be the case.

Example 1:

Metastatic liver cancer

PDX: C80 Malignant neoplasm without specification of site

M8000/3 Neoplasm, malignant, primary site

SDX: C78.7 Secondary malignant neoplasm of liver

M8000/6 Neoplasm, malignant, metastatic site

Example 2:

A patient with breast cancer is admitted for pain relief of chronic intractable pain due to bony secondaries.

PDX: C79.5 Secondary malignant neoplasm of bone and bone marrow

M8000/6 Neoplasm, malignant, metastatic site

SDX: R52.1 Chronic intractable pain

SDX: C50.9 Malignant neoplasm, breast, unspecified

M8000/3 Neoplasm, malignant, primary site

Example 3:

A patient admitted with Kaposi's sarcoma of the skin as a result of HIV

PDX: B21.0 HIV disease resulting in Kaposi's sarcoma

SDX: C46.0 Kaposi's sarcoma of skin

M9140/3 Kaposi's sarcoma, primary site

Guidelines for coding “Metastatic Cancer”

“Metastatic from”

Cancer described as “metastatic from” a site should be interpreted as primary of the stated site. Also assign the code for the secondary neoplasm of the specified site (if the secondary site is identified), or for the secondary malignant neoplasm of unspecified site (if the secondary site is not identified).

Example:

Metastatic spread from the breast

PDX: C50.9 Malignant neoplasm, breast, unspecified

M8000/3 Neoplasm, malignant, primary site

SDX: C80 Malignant neoplasm without specification of site

M8000/6 Neoplasm, malignant, metastatic site

“Metastatic to”

Cancer described as “metastatic to” a site should be interpreted as secondary of the stated site. Also assign the code for the primary neoplasm of the specified site (if the primary site is known and still present), or for the primary malignant neoplasm of unspecified site (if the primary site is not identified)

“Metastatic to / of” code as secondary of stated site.

Example:

Metastatic carcinoma to the breast

PDX: C80 Malignant neoplasm without specification of site

M8000/3 Neoplasm, malignant, primary site

SDX: C79.8 Secondary malignant neoplasm of other specified sites

M8000/6 Neoplasm, malignant, metastatic site

Overlapping Lesions

Where the tumour has overlapping site boundaries and the point of origin is not clear, select a code for neoplasm overlapping site boundaries.

If two or more sites are given for the tumour and no point of origin is indicated and if coded individually these sites give different four character codes within the same three character rubric, then the code for overlapping site boundaries is required.

Full notes regarding the rules for coding malignant neoplasms with overlapping site boundaries can be found in the Tabular list in Chapter II. Overlapping lesions cannot be found in the Alphabetical index.

Guideline

Locate the codes individually in the Alphabetical index.

Example:

Carcinoma of the tip and ventral surface of the tongue.

PDX: C02.8 Malignant neoplasm, overlapping lesion of tongue

M8010/3 Carcinoma NOS, primary site

Recurrent Malignancy

Recurrent malignancy is generally considered to be a new primary lesion in the same site as the previous malignant neoplasm that has been excised or eradicated.

Guideline:

When the primary neoplasm has been eradicated or excised, and has not recurred, it is coded as a “history of”.

If the malignant neoplasm has recurred or is recurrent then follow the usual rule and code the malignant neoplasm.

Example:

Recurrent malignant neoplasm of posterior wall of bladder

PDX: C67.4 Malignant neoplasm, posterior wall of bladder

M8000/3 Neoplasm, malignant, primary site

History of Neoplasm

The code for history of a primary malignancy is used when the primary is no longer present and the intended course of treatment for it has been completed. The history code should not be used in the primary position with the exception of Z85.6 and Z85.7. Refer to standard on "Remission in leukemia and other malignant lymphoid and haematopoietic neoplasms"

"History of neoplasm"

Code as such if:

- The clinician has described or recorded it as such.
- The treatment of the malignant neoplasm has been completed and there is no evidence to suggest that the treatment has been unsuccessful.
- So long as the intended treatment for the malignant neoplasm is ongoing or there is evidence that the disease is still present, the code for malignant primary should be used.
- History of malignant neoplasm is classified to category **Z85 Personal history of malignant neoplasm** with the fourth-character denoting specific body systems / sites.

Example:

Patient has a personal history of breast cancer previously removed with spread to the ovaries.

PDX: C79.6 Secondary malignant neoplasm of ovary

M8000/6 Neoplasm, malignant, metastatic site

SDX: Z85.3 Personal history of malignant neoplasm of breast

Standard

Code **Z40.0 Prophylactic surgery for risk-factors related to malignant neoplasms** is used in the primary position if the patient is being admitted solely for the purpose of undergoing prophylactic surgery.

Example:

Patient admitted for a prophylactic orchidectomy. He had a prostatectomy six months ago for carcinoma of prostate that has been completely eradicated.

PDX: Z40.0 Prophylactic surgery for risk-factors related to malignant neoplasms

SDX: Z85.4 Personal history of malignant neoplasm of genital organs

Follow-up Examinations

The category **Z08 Follow-up examination after treatment for malignant neoplasm** can be used in the primary position followed by a code from Z85 for patients with a history of a malignant neoplasm in whom no recurrence is found.

Example:

Colonoscopy for adenocarcinoma of colon with no recurrence found.

PDX: Z08.9 Follow-up examination after unspecified treatment for malignant neoplasm

SDX: Z85.0 Personal history of malignant neoplasm of digestive organs

If there is a recurrence of the malignant neoplasm found on examination, then code the malignant neoplasm only.

Guideline

Sometimes a patient will have a further excision of a neoplasm. In this instance, continue to use the code for the neoplasm even if the histology result for the further tissue excised reports it to be disease free.

Remission in leukemia and other malignant lymphoid and haematopoietic neoplasms

Standard

Z85.6 Personal history of leukaemia and Z85.7 Personal history of other malignant neoplasms of lymphoid, haematopoietic and related tissues are used to identify patients who are in remission and admitted for maintenance chemotherapy.

PDX: Z85.6 Personal history of leukaemia

SDX: Z51.1 Chemotherapy session for neoplasm

Or

PDX: Z85.7 Personal history of other malignant neoplasms of lymphoid, haematopoietic and related tissues

SDX: Z51.1 Chemotherapy session for neoplasm

Coding of radiotherapy and chemotherapy treatment for neoplasms

Radiotherapy

The treatment of disease by means of ionizing radiation, tissue may be exposed to a beam of radiation, or a radioactive element may be contained in devices and inserted directly into the tissues or it may be introduced into a natural body cavity.

Chemotherapy

The treatment of diseases by chemical agents.

Standard

Z51.0 Radiotherapy session

This code should be assigned in the secondary position.

Z51.1 Chemotherapy session for neoplasm

This code should be assigned in the secondary position.

This code is used for chemotherapy for the neoplasm and for maintenance chemotherapy.

Example:

Patient admitted for chemotherapy following oophorectomy for malignant teratoma.

PDX: C56 Malignant neoplasm of ovary

M9080/3 Teratoma, malignant, primary site, NOS

SDX: Z51.1 Chemotherapy session for neoplasm

Guideline

Z51.2 Other chemotherapy

This code is to be used for chemotherapy NEC or for any other reason other than chemotherapy for neoplasms.

Uncertain / Unknown Behaviour (rarely used)

Uncertain

Neoplasms whose behaviour cannot be determined at the time of discovery.

This includes tissue beginning to exhibit neoplastic behaviour but cannot be categorized as benign or malignant.

Unknown

Neoplasms of an unspecified morphology and behaviour.

Benign neoplasm

Non-cancerous tumours. Benign tumours may grow slowly, but they do not invade local tissues or spread to other parts of the body and are usually not life threatening.

The SA ICD-10 Coding Standards are to be used concurrently with the ICD-10 volumes and training material.

Guideline

It is not necessary to code anaemia in malignant blood disorders such as leukaemia.

Example:

Admission for anaemia in myelodysplasia

PDX: D46.9 Myelodysplastic syndrome, unspecified

Guideline

In the second edition of ICD-10, code C14.1 Malignant neoplasm, laryngopharynx has been deleted (WHO corrigenda 1995), however in volume 3 of the second edition, in the Neoplasm table:

Neoplasm

– laryngopharynx

Takes you to code C14.1

To maintain consistency

Neoplasm

– laryngopharynx

Change the above from C14.1 to C13.9 in the alpha index as per hypopharynx

Neoplasm

– hypopharynx C13.9

(Hypopharynx and laryngopharynx are the same)

[Reference – Working Group Meeting held on 17 July 2007, ICD-10 National Task Team]

Diagnosis Standard National – 03

Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50 – D89)

DSN0301 Anaemia due to Chronic Renal Failure

The anaemia resulting from chronic renal failure is mainly due to a deficiency of a hormone called erythropoietin (Epo). Epo is produced by the kidney to stimulate red blood cell production from the bone marrow. A deficiency of Epo leads to anaemia.

Often the anaemia of renal failure can be helped by taking iron. Some people remain short of iron even when taking iron tablets. If so, they may need a course of intravenous iron injections. This is usually done at the hospital on an out patient basis.

With more severe anaemia, a patient may be prescribed Epo which has to be given as injections, usually once or twice a week.

Coding of anaemia due to chronic renal failure:

PDX: **N18.8+** Other chronic renal failure

SDX: **D63.8*** Anaemia in other chronic diseases classified elsewhere

Or

PDX: **N18.9+** Chronic renal failure, unspecified

SDX: **D63.8*** Anaemia in other chronic diseases classified elsewhere

[Reference – Minutes of the Technical Subcommittee meeting held on 18 January 2006, ICD-10 National Task Team]

DSN0302 Coding Haemophilia with Epistaxis

For haemophilia with epistaxis or other haemorrhage it will be assumed that the bleeding is linked to the haemophilia. Therefore, in a case where the bleeding represents an important problem in medical care, haemophilia will be recorded first with the appropriate code for the bleed in the secondary position.

Example:

Patient admitted and taken to theatre for surgical control of epistaxis. Patient is a known haemophiliac

PDX: **D66** Hereditary factor VIII deficiency

SDX: **R04.0** Epistaxis

[Reference – Minutes of the Technical Subcommittee meeting held on 05 July 2006, ICD-10 National Task Team]

Diagnosis Standard National – 04

Endocrine, nutritional and metabolic diseases (E00 – E90)

DSN0401 Non-insulin dependent diabetic who requires insulin

There is currently no appropriate ICD-10 classification for a non-insulin dependent diabetic patient who occasionally requires insulin therapy. In the current ICD-10 classification, the patient should be coded as non-insulin dependent. For classification of a diabetic patient who is non-insulin dependent, but receives insulin periodically as part of the treatment regime, E11 Non-insulin-dependent diabetes mellitus should be used as the South African standard and specified to the appropriate 4th character [E11.–].

[Reference – Final Document, ICD-10 implementation, August 2004]

DSN0402 Obesity

It was noted that schemes may request BMI's (Body Mass Index) for motivation purposes but that this is not required (or catered for) on the standards claim form.

Medical practitioner service modifier 0018 is used as an obesity indicator for medical practitioners.

[Extract from the draft minutes of the ICD-10 Technical Subcommittee meeting held on May 31, 2006]

Medical practitioner service code and description

Modifier 0018 Surgical modifier for persons with a BMI of 35> (calculated according to kg/m²): Fee for procedure +50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists

[Reference – Medical Practitioner's Guide to Fees, 2006]

The WHO classification of "overweight" and "obesity" is as follows:

Overweight (grade 1 obesity) is defined as a BMI of 25 – 29.9kg/m²

Obesity (grade 2) as BMI 30 – 39.9 kg/m²

Morbid Obesity (grade 3) as BMI > 40kg/m²

These BMI ranges apply to post-pubertal Caucasoid individuals. For children and pre-pubertal adolescent patients, age specific standards should be consulted and / or the clinician be requested to clarify the categorization of obesity / overweight.

In practice abnormal and excessive fat distribution can also be measured by the waist hip ratio (WHR) with abnormal WHR being > 0.90 in men and > 0.85 in women.¹

[Reference – Australian Coding Standards, Third Edition, ICD-10 AM]

¹ Extracted from NCCH ICD-10-AM, July 2002, Endocrine, Nutritional and Metabolic Diseases.

Diagnosis Standard National – 09

Diseases of the circulatory system (I00 – I99)

DSN0901 Coding of the Circulatory System

Rule

Sometimes ICD-10 assumes that certain valve disorders of unspecified etiology are rheumatic in origin, e.g. I05.0: Mitral valve stenosis is coded to the rheumatic section while I34.0: Mitral valve insufficiency is not

Hypertension and cardiac conditions

Rule:

For hypertension and cardiac conditions, only presume a link or causal relationship between the two conditions if it is clearly stated by the physician that the cardiac condition is due to the hypertension. Phrases such as hypertensive and due to hypertension indicate a causal relation.

Example: Hypertensive congestive cardiac failure

Index trail:

Lead term = hypertensive:

Hypertension, hypertensive (accelerated) ...

- heart (disease) (conditions in I51.4-I51.9 due to
hypertension I11.9

- - with

- - - heart failure (congestive) ... I11.0

Tabular: I11.0: Hypertensive heart disease with (congestive) heart failure

The correct code is I11.0 (There is a causal link)

When the clinical notes do not indicate a causal relationship or a link between the hypertension and the cardiac conditions, list each condition individually.

Example: Congestive cardiac failure with hypertension

Index trail:

Lead term = failure, with the following essential modifiers:

Failure, failed

- heart (acute) (sudden) I50.9

- - congestive I50.0

Tabular: I50.0 Congestive heart failure

Next lead term = Hypertension in index:

Hypertension, hypertensive (accelerated) I10

Tabular: I10 Essential (primary) hypertension

The correct codes and sequence are: I50.0 and I10.

Guideline

For hypertensive cardiomegaly, use additional code I51.7 to indicate the presence of the cardiomegaly

Example: Hypertensive cardiomegaly

Codes: I11.9: Hypertensive heart disease without (congestive) heart failure

I51.7: Cardiomegaly (for additional information, even though the note under I51 indicates that it may not be coded)

Hypertension and renal disease or conditions

Rule

For hypertension and renal disease or renal failure ICD-10 presumes a causal relationship between the hypertension and the renal disease or renal failure.

Example: Renal failure with hypertension

Code: I12.0: Hypertensive renal disease with renal failure

Guideline

Block category I12

Code conditions from N18.- as additional codes as they provide valuable information

Example: Hypertensive end stage renal failure

PDX: I12.0: Hypertensive renal disease with renal failure

SDX: N18.0: End-stage renal disease

Secondary Hypertension

Rule

Codes from block category I15: Secondary Hypertension cannot be used as primary codes unless secondary hypertension is the reason for medical care or main condition treated.

Guideline

Elevated blood pressure is coded to I10: Essential (primary) hypertension

Elevated blood pressure reading is coded to R03.0: Elevated blood pressure reading, without diagnosis of hypertension

Definition

Hypertension: High arterial blood pressure

Hypertensive:

- Characterised by increased pressure or tension
- An agent that causes hypertension
- A person with hypertension

Dorland's Medical Dictionary, 29th Edition

In coding terms, the word "hypertensive" and "due to hypertension" assumes a causal relationship with the hypertension and other diseases.

Ischaemic Heart Disease

Rule

In order to code myocardial infarctions correctly, one needs the following information:

- The site of infarction, e.g. anterior wall, posterior wall, etc
- Whether it is new (acute or occurring within the last 28 days)
- Whether it is subsequent (a 2nd or 3rd MI within 28 days)
- Whether it is an old MI still causing problems or requiring investigation or treatment (chronic or occurred more than 28 days ago)
- Whether it is an old MI not causing any problems or symptoms but relevant to the current episode of care

Guidelines

- I25.2: Old myocardial infarction, is essentially a "history code" even though it does not appear in chapter 21 (Z codes). It should be assigned as an additional code if the following is applicable:
- The old MI occurred more than 28 days ago
- The patient is currently NOT receiving care (observation, evaluation or treatment) for the MI
- Do not code pleural effusion with congestive heart failure
- Acute pulmonary oedema is a common symptom of heart failure and is usually coded to I50.1: Left ventricular failure

The SA ICD-10 Coding Standards are to be used concurrently with the ICD-10 volumes and training material.

- Post myocardial infarction angina is coded as secondary diagnosis
- Code: I46.9: Cardiac arrest, unspecified is to be used when a patient had a cardiac arrest, was resuscitated and dies
- Ischaemic heart disease (IHD) should not be coded with coronary artery disease and arteriosclerotic heart disease. IHD is a general term that is used to reflect many conditions that affect the heart due to inadequate blood supply. Specific information must be obtained to code appropriately for codes ranging between (I20-I25)

Heart Failure

Guideline

Biventricular heart failure can either be coded to:

- I50.0: Congestive heart failure, or
- I50.9: Heart failure unspecified

Diagnosis Standard National – 10

Diseases of the respiratory system (J00 – J99)

DSN1001 Coding of both sinusitis and bronchitis

No combination code exists in ICD-10 for the coding of sinusitis and bronchitis therefore the two conditions (sinusitis and bronchitis) either need to be coded separately (with bronchitis as the primary diagnosis) or according to the correct WHO rules, it would be appropriate to code to the 'lowest' anatomical site or area affected, i.e. the bronchi, thus bronchitis would be the correct code of choice.

[Reference – Final Document, ICD-10 implementation, August 2004]

DSN1002 Bronchitis

J20 Acute bronchitis versus J40 Bronchitis not specified as acute or chronic

Bronchitis not specified as acute or chronic in those under 15 years of age can be assumed to be of acute nature and should be classified to J20.–.

[Reference – Minutes of the Technical Subcommittee meeting held on 15 March 2006, ICD-10 National Task Team]

DSN1003 Avian Flu

J09 Influenza due to identified avian influenza virus is the correct code to use for avian flu from the 01 September 2007. This code replaces the use of J10.8 as specified in this standard.

J10.8 Influenza with other manifestations, influenza virus identified should be used to indicate Avian flu until the ICD-10 Master Industry Table is updated to include code **J09** which is a new code to specifically indicate Avian flu. [Confirmed from the WHO corrigenda]

Code **Z25.8 Need for immunization against other specified single viral diseases** is the appropriate code to use to indicate vaccination for Avian flu.

[Reference – Minutes of the Technical Subcommittee meeting held on 05 April 2006, ICD-10 National Task Team]

DSN1004 Coding Chronic Obstructive Pulmonary Disease (COPD) / Chronic Obstructive Airways Disease (COAD) and Emphysema

Code COPD / COAD and Emphysema separately when coding both, Chronic Obstructive Pulmonary Disease (COPD) / Chronic Obstructive Airways Disease (COAD) and Emphysema.

COPD / COAD and Emphysema have different aetiologies and treatments and cannot be coded using one code only.

The primary code would be determined by the main condition treated.

Example:

Patient admitted with COPD and Emphysema

PDX: J44.9 Chronic obstructive pulmonary disease, unspecified

SDX: J43.9 Emphysema, unspecified

[Reference – Minutes of the Technical Subcommittee meeting held on 02 August 2006, ICD-10 National Task Team]

DSN1005 Coding Chest Infection

J22 Unspecified acute lower respiratory infection is accepted as the standard for coding “unspecified chest infection” when no indication of the affected chest part has been given. If it has been mentioned, code to the appropriate anatomical site.

[Reference – Minutes of the Technical Subcommittee meeting held on 02 August 2006, ICD-10 National Task Team]

DSN1006 Coding prophylactic administration Palivizumab (Synagis®)

Palivizumab (Synagis®) is a humanised monoclonal antibody targeted to the F protein of the respiratory syncytial virus.

Z29.8 Other specified prophylactic measures should be used for the prophylactic administration of Palivizumab (Synagis®).

[Reference – Working Group Meeting held on 17 July 2007, ICD-10 National Task Team]

Diagnosis Standard National – 12

Diseases of the skin and subcutaneous tissue (L00 – L99)

DSN1201 Cosmetic surgery for skin laxity following weight loss

Code to

PDX: L98.8 Other specified disorders of skin and subcutaneous tissue

SDX: Z41.1 Other plastic surgery for unacceptable cosmetic appearance

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

Diagnosis Standard National – 13

Diseases of the musculoskeletal system and connective tissue (M00 – M99)

DSN1301 Necrotizing Fasciitis

M72.6 Necrotising fasciitis with the appropriate fifth character code is the correct code to use for necrotising fasciitis from the 01 September 2007. This code replaces the use of M72.5 as specified in this standard.

M72.5 Fasciitis, not elsewhere classified should be used for necrotizing fasciitis. A concern was raised that this code falls under fibroblastic disorders. Based on the Australian Modification and the use of an ICD-10 AM code **M72.6** which also falls under **M72 fibroblastic disorders** it was agreed that we continue to use this code until South Africa is able to make additions to our ICD-10 database. **M72.5** with its fifth character site code to be used in the primary position, with an option to include a code for the causative organism in the secondary position, if known.

[Reference – Minutes of the Technical Subcommittee meeting held on 9 March 2005, ICD-10 National Task Team]

DSN1302 Subsequent hip replacement following an old hip replacement

Use code **M96.8 Other postprocedural musculoskeletal disorders** when a patient presents with instability and pain following an old hip replacement and has a subsequent replacement of a new hip replacement.

[Reference – Minutes of the Technical Subcommittee meeting held on 18 January 2006, ICD-10 National Task Team]

DSN1303 Osteopaenia

The appropriate code for **Osteopaenia** is **M85.8 Other specified disorders of bone density and structure** with the appropriate fifth (5th) character code.

[Reference – Minutes of the Technical Subcommittee meeting held on 08 August 2005, ICD-10 National Task Team]

DSN1304 Coding of Osteoarthritis

When coding osteoarthritis and no information is documented as to whether the osteoarthritis is primary, secondary etc. use the default noted below the title Arthrosis, block category (M15 – M19)

Note: In this block the term osteoarthritis is used as a synonym for arthrosis or osteoarthritis. The term primary has been used with its customary clinical meaning of no underlying or determining condition identified.

[Reference – Minutes of the Technical Subcommittee meeting held on 09 May 2007, ICD-10 National Task Team]

Diagnosis Standard National – 14

Diseases of the genitourinary system (N00 – N99)

DSN1401 Coding of Dialysis

This dialysis code should be assigned in the secondary position and the reason for the dialysis (condition requiring dialysis) sequenced as the primary code.

Renal Dialysis

Z49.1 Extracorporeal dialysis

Dialysis (renal) NOS

Z49.2 Other dialysis

Peritoneal dialysis

Example:

Patient admitted for dialysis for chronic renal failure

PDX: N18.9 Chronic renal failure, unspecified

SDX: Z49.1 Extracorporeal dialysis

[Reference – Working Group Meeting held on 17 July 2007, ICD-10 National Task Team]

Diagnosis Standard National – 16

Certain conditions originating in the perinatal period (P00 – P96)

DSN1601 Neonatal Bronchiolitis

Use two codes to describe neonatal bronchiolitis

PDX: P28.8 Other specified respiratory conditions of newborn

SDX: J21.9 Acute bronchiolitis, unspecified

[Reference – Minutes of the Technical Subcommittee meeting held on 18 January 2006, ICD-10 National Task Team]

Diagnosis Standard National – 18

Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00 – R99)

Guidelines when using R-codes

Signs and symptoms that point rather definitely to a given diagnosis should be coded as the given diagnosis. The codes for the definitive diagnosis are assigned to the specific category in the specific chapter of the classification.

Example:

Patient presenting with photophobia, fever and neck stiffness. Diagnosis – Meningitis

Code the definitive diagnosis – Meningitis

Code: G03.9 Meningitis, unspecified

You do not have to code the symptoms.

- “R” codes can be used as the main condition in the following situations:
 - a) cases for which no more specific diagnosis can be made even after all the facts bearing on the case have been investigated.
 - b) signs or symptoms existing at the time of initial encounter that proved to be transient and whose causes could not be determined.
 - c) provisional diagnosis in a patient who failed to return for further investigation or care.
 - d) cases referred elsewhere for investigation or treatment before the diagnosis was made.
 - e) cases in which a more precise diagnosis was not available for any other reason.
 - f) certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right.
- “R” codes can be assigned as additional information where appropriate.
- Sign and Symptoms are also allocated to relevant chapters in the classification and therefore may not be always identified as an “R” code e.g. backache is coded as “M54.99” and is allocated to chapter XIII (Diseases of the Musculoskeletal System and Connective Tissue).
- “R” codes can also be used as the main code when used together with a sequelae code, e.g.: Dysphagia sequelae to CVA

Diagnosis recorded as “possible” or “suggestive of” or “probable” or prefixed with a “?” or “query” will not be coded as if the given diagnosis is confirmed. This will remain the case regardless of the treatment that has been provided to the patient. In such circumstances the coder will record the relevant symptoms. The terms “possible” and “suggestive of” and the use of the “?” will be taken to mean that there remained a significant element of doubt as to the actual diagnosis and that the differential diagnoses were still being considered (or that the patient appeared to be recovering so further investigations were not being undertaken but that there was a significant level of uncertainty over the actual diagnosis).

Where a diagnosis has been made and recorded but this diagnosis is subsequently proven to be incorrect, the final (actual diagnosis) will be coded. This will be the case regardless of the treatment that has been provided to the patient.

DSN1801 Coding a Death

R99 Other ill-defined and unspecified causes of mortality is the agreed industry standard to indicate death when no other cause of death is indicated.

[Reference – Minutes of the Technical Subcommittee meeting held on 15 March 2006, ICD-10 National Task Team]

Diagnosis Standard National – 19

Injury, poisoning and certain other consequences of external causes (S00 – T98)

DSN1901 Poisoning, Overdose and Adverse Effects

Poisoning

A poisoning is identified as the:

- Wrong dosage given or taken
- Wrong medication given or taken
- Medication given or taken by the wrong person
- Intoxication (other than cumulative effect)
- Overdose
- Correct medicine taken with alcohol or nonprescription drug, causing an unexpected adverse effect.
- Correct medicine taken with alcohol causing an unexpected adverse effect.
- Correct medicine taken with non prescription drug, causing an unexpected adverse effect.
- Wrong route of administration
- Therapeutic misadventure
- Toxic effect / Toxicity

Guideline

Code each drug individually if multiple drugs

Code manifestation in addition to the poisoning code and then the external cause code

A poisoning should be coded as undetermined if is not stated as accidental or intentional.

Example:

A 4-year old is admitted for poisoning. She is drowsy and not responding. She accidentally ingested her grandmother's valium which was left on the kitchen table at home.

PDX: T42.4 Poisoning: benzodiazepines

SDX: R40.0 Somnolence

SDX: X41.09 Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, home, during unspecified activity

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

Overdose

Cross reference as a poisoning

Code each drug individually if multiple drugs

Code manifestation in addition to the poisoning code and then the external cause code

Guideline

Code to a poisoning, undetermined intent, if there is no further information. If there is evidence to the contrary, code accordingly.

Example:

Overdose of tranquilizers.

PDX: T43.5 Poisoning: other and unspecified antipsychotics and neuroleptics

SDX: Y11.99 Poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent, unspecified place, during unspecified activity

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

Adverse Effects

An adverse effect is identified as the:

- Allergic reaction
- Cumulative effect of drug taken or given correctly (toxicity)
- Hypersensitivity to drug
- Idiosyncratic reaction
- Paradoxical or synergistic reaction
- Side effects
- Drug interaction

Example:

Patient has gastritis due to the aspirin he is taking as prescribed by his doctor.

PDX: K29.7 Gastritis, unspecified

SDX: Y45.1 Adverse effects in therapeutic use: salicylates

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

DSN1902 Unregistered and trial Drugs

If a patient has a reaction to a drug that is in clinical trials and the drug is used “correctly” meeting the definition of an adverse reaction, code it as an adverse reaction to a drug in therapeutic use. The assumption would be that even though the drug is not yet registered, it has been prescribed by a physician and therefore administered as intended.

If a patient has a reaction to a drug that is in clinical trials and the drug is used “incorrectly” meeting the definition of a poisoning, code as a poisoning.

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

DSN1903 Herbal Enemas

Code to:

PDX: T50.9 Other and unspecified drugs, medicaments and biological substances

SDX: Y14.– Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent

or

Y57.9 Drug or medicament, unspecified

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

DSN1901 Sexual harassment at the workplace

Code the sign and symptom codes first followed by Z56.6 Other physical and mental strain related to work.

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

Diagnosis Standard National – 20

External causes of morbidity and mortality (V01 – Y98)

DSN2001 External Cause Codes

Undetermined Intent

Code **Y34.99 Unspecified event, undetermined intent, unspecified place, during unspecified activity** is the appropriate external cause code to be used when no additional causative information is available regarding an injury. There are other external cause codes for poisoning etc.

[Reference – Minutes of the Task Team meeting held on 20 October 2004, ICD-10 National Task Team]

[Reference – Minutes of the Technical Subcommittee meeting held on 05 April 2006, ICD-10 National Task Team]

External Cause Codes (ECC's) – Public Road

The definition of a “highway” as mentioned in the ECC's is standardised as a “public road” for local interpretation.

[Reference – Minutes of the Technical Subcommittee meeting held on 06 July 2005, ICD-10 National Task Team]

External Cause Codes (ECC's) – Minibus

The definition of a “minibus” as known in SA terms was allocated to definition (n) in the ECC section of Volume 1 of the ICD-10 manuals: “A *car* [*automobile*] is a four-wheeled motor vehicle designed primarily for carrying up to 10 persons.”

If more than 10 people are being carried, the definition of the transport vehicle would fall under that of definition (q): “A *bus* is a motor vehicle designed or adapted primarily for carrying more than 10 persons, and requiring a special driver's licence.”

[Reference – Minutes of the Technical Subcommittee meeting held on 06 July 2005, ICD-10 National Task Team]

External Cause Codes (ECC's) – Quad Bike

This would fall under definition (w) as per Volume 1 of the ICD-10 manual: “A special all-terrain vehicle is a motor vehicle of special design to enable it to negotiate rough or soft terrain or snow. Examples of special design are high construction, special wheels and tyres, tracks, and support on a cushion of air.”

[Reference – Minutes of the Technical Subcommittee meeting held on 06 July 2005, ICD-10 National Task Team]

External Cause Codes (ECC's) – Hijacking

The meeting determined that there is no specific code for hijacking but that examples of codes from the ranges Y04, Y08 etc should be used as the external cause code to indicate the method by which the hijacking occurred.

[Reference – Minutes of the Technical Subcommittee meeting held on 06 July 2005, ICD-10 National Task Team]

The SA ICD-10 Coding Standards are to be used concurrently with the ICD-10 volumes and training material.

Guideline for External Cause Codes Y40 – Y84

The above range of ICD-10 codes are external cause codes which describe complications of medical and surgical care. Please read the full description before opting to use these codes.

Please take note when selecting codes in the Y40 – Y84 range from the ICD-10 manuals. 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 you do not get confused in using these codes to inappropriately indicate that a service or treatment was performed.

Examples:

Y40.0

The description next to this code in the ICD-10 manual states “Penicillins”. This code may thus be misinterpreted to indicate that the patient received penicillin treatment. However, when you review the full heading description, the actual code description reads as “Adverse effects in therapeutic use: penicillins” which now indicates a **complication or adverse effect** of treatment.

Y48.– (Anaesthetic and therapeutic gases) codes are being used incorrectly to indicate that some form of anaesthetic was administered; the intention of these codes is actually to indicate “Drugs, medicaments and biological substances causing adverse effects in therapeutic use.”

Y84.0

The description in the manual indicates “Cardiac catheterization”, while the full description reads “Abnormal reaction/late complication: cardiac catheterization”

The full descriptions of all these complication codes are included on the Master Industry Table (MIT).

[Reference – Circular no. 14 of 2007, Council for Medical Schemes]

Diagnosis Standard National – 21

Factors influencing health status and contact with health services (Z00 – Z99)

DSN2101 Code for No Abnormalities Detected

The code **Z03.9 Observation for suspected disease or condition, unspecified** is the South African standard for no abnormalities detected (NAD). This code can be used for persons who present with symptoms and / or evidence of an abnormal condition which requires study, but who, after examination, investigation and / or observation, show no need for further treatment and / or medical care.

Example 1:

Patient for a Computerised Axial Tomography (CAT) scan of the head, presenting with severe headaches. As per referral note from the General Practitioner, **R51 Headache** is the ICD-10 code used. According to the patient's history, the headaches are possibly related to a head injury which the patient sustained in a motor vehicle accident which occurred 14 months ago. No abnormalities detected on the scan. For record purposes, **Z03.9 Observation for suspected disease or condition, unspecified** will be used to indicate that no abnormalities were detected.

[Reference – Final Document, ICD-10 implementation, August 2004]

DSN2102 Routine Examination, Radiology

Code **Z01.6 Radiological examination, not elsewhere classified** is the appropriate code to use when a routine examination is done.

[Reference – Final Document, ICD-10 implementation, November 2004]

DSN2103 Routine Examination, Pathology

Code **Z01.7 Laboratory examination** is the appropriate code to use when a routine examination is done.

[Reference – Final Document, ICD-10 implementation, November 2004]

DSN2104 Diagnosis for Rule D, Cancellation of appointments

Rule D – Cancellation of appointments: Unless timely steps are taken to cancel an appointment for a consultation, the relevant consultation fee may be charged. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor's rooms as the case may be.

[Reference – Medical Practitioners Guide to Fees 2005]

The following ICD-10 codes were accepted at a technical level when "Rule D" is used in cases where a patient did not turn up for a procedure or consultation, but for which the provider is still entitled to bill the patient. (This would be a private account as most schemes do not reimburse for services not carried out.) The word "procedure" in the description is deemed to refer to all "medical services" including consultations.

- Z53.2 Procedure not carried out because of patient's decision for other and unspecified reasons.
- Z53.8 Procedure not carried out for other reasons.
- Z53.9 Procedure not carried out, unspecified reason.

[Reference – Minutes of the Technical Subcommittee meeting held on 9 February 2005, ICD-10 National Task Team]

DSN2105 Routine Dental Examination

Z01.2 Dental examination is the appropriate code to use for a routine dental examination in which no diagnosis is made and / or no treatment is rendered.

[Reference – Minutes of the Technical Subcommittee meeting held on 9 February 2005, ICD-10 National Task Team]

DSN2106 Emergency Radiology

Z01.9 Special examination, unspecified is the appropriate code to use by radiologists when “emergency radiology was performed and for which the actual x-ray is not available for reporting / diagnosing purposes”.
Reminder – this code can also still be used by other providers for different purposes.

[Reference – Minutes of the Technical Subcommittee meeting held on 05 April 2006, ICD-10 National Task Team]

DSN2107 Non-surgical Prophylactic Measures

Z29.2 Other prophylactic chemotherapy is the appropriate code to use for prophylactic treatment that is not surgical in nature.

Guideline

Z29.2 Other prophylactic chemotherapy does not refer only to chemotherapy for cancer treatment, it is also appropriate for other medication e.g. antibiotics, antiparasitics etc.

Z29.8 Other specified prophylactic measures is the appropriate code to use with other prophylactic measures which are not chemical, medical or surgical in nature.

[Reference – Minutes of the Technical Subcommittee meeting held on 05 April 2006, ICD-10 National Task Team]

DSN2108 Consultation, taking patient history from a family member

Code Z71.0 Person consulting on behalf of another person is the appropriate code to use when a psychologist is getting a history from e.g. a parent, regarding a child or family member and the patient is not actually present during the consultation.

[Reference – Minutes of the Technical Subcommittee meeting held on 9 March 2005, ICD-10 National Task Team]

DSN2109 Re-cementation of a Crown / Bridge

Code Z46.3 Fitting and adjustment of dental prosthetic device is the appropriate code for re-cementation of a crown / bridge.

[Reference – Minutes of the Technical Subcommittee meeting held on 9 March 2005, ICD-10 National Task Team]

DSN2110 Repair of a Denture

Code Z46.3 Fitting and adjustment of dental prosthetic device is the appropriate code for repair of a denture.

[Reference – Minutes of the Technical Subcommittee meeting held on 9 March 2005, ICD-10 National Task Team]

DSN2111 Frames sold without lenses being fitted

Code **Z41.9 Procedure for purposes other than remedying health state, unspecified** is the appropriate code for use when frames are sold without lenses being fitted.

[Reference – Minutes of the Technical Subcommittee meeting held on 4 May 2005, ICD-10 National Task Team]

DSN2112 Repairs and Adjustments to appliances

Code **Z46.0 Fitting and adjustment of spectacles and contact lenses** is the appropriate code for repairs and adjustments to appliances e.g. spectacles

[Reference – Minutes of the Technical Subcommittee meeting held on 4 May 2005, ICD-10 National Task Team]

DSN2113 Repeat prescription for spectacles

Z76.0 Issue of repeat prescription is the appropriate code for issue of repeat prescription for spectacles.

[Reference – Minutes of the Technical Subcommittee meeting held on 4 May 2005, ICD-10 National Task Team]

DSN2114 Binocular Vision Therapy

Z50.6 Orthoptic training includes binocular vision therapy.

[Reference – Minutes of the Technical Subcommittee meeting held on 4 May 2005, ICD-10 National Task Team]

DSN2115 Pharmacy Standards

The following ICD-10 codes would be acceptable for use as described:

1. For no ICD-10 code on a script, use **Z76.9 Person encountering health services in unspecified circumstances**
2. For telephone scripts, use **Z76.8 Persons encountering health services in other specified circumstances**
3. For PAT (Pharmacy Advised Treatment) or claimable OTC's (Over-the-counter medicine), **R codes** (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified) can be used.
4. For Glucose, Urine, Peak Flow screening tests **Z13.8 Special screening examination for other specified diseases and disorders** is the appropriate code unless the screening test is done for a specific diagnosis, for example, glucose screening test for diabetes would be coded to **Z13.1 Special screening examination for diabetes mellitus**

[Reference – Minutes of the Technical Subcommittee meeting held on 01 June 2005, ICD-10 National Task Team]

DSN2116 ICD-10 Codes linked to each material code per line

Z01.6 Radiological examination, not elsewhere classified should be used to indicate that a material code was used until such time the software program is updated to code the material with the correct ICD-10 code(s).

[Reference – Minutes of the Technical Subcommittee meeting held on 01 June 2005, ICD-10 National Task Team]

DSN2117 Sports Mouth Guard

A Sports Mouth Guard [e. g. like a boxers gum guard] is used as a prophylactic measure and is designed to stop teeth from breaking during sports.

Z29.8 Other specified prophylactic measures is the appropriate code to use for a Sports Mouth Guard.

[Reference – Minutes of the Technical Subcommittee meeting held on 06 July 2005, ICD-10 National Task Team]

DSN2118 Routine Bone Density Test / Densitometry

The code **Z01.6 Radiological examination, not elsewhere classified** is the appropriate code for use in the primary position for a routine bone density test or densitometry. If there are any significant findings, the appropriate ICD-10 code should be used.

Example 1:

Patient found to have postmenopausal osteoporosis of the hip following a routine bone density test.

PDX: M81.05 Postmenopausal osteoporosis, pelvic region and thigh

Example 2:

No abnormalities detected following a routine bone density test.

PDX: Z01.6 Radiological examination, not elsewhere classified

[Reference – Minutes of the Technical Subcommittee meeting held on 03 August 2005, ICD-10 National Task Team]

DSN2119 Routine Newborn Examinations

Code **Z00.1 Routine child health examination** is the appropriate code for routine newborn examinations as per rules from volume 3 of ICD-10, the Alphabetical Index.

[Reference – Minutes of the Technical Subcommittee meeting held on 03 August 2005, ICD-10 National Task Team]

DSN2120 Antenatal Classes

ICD-10 code **Z71.8 Other specified counseling** is the appropriate code to be used for Antenatal / Childbirth Education classes.

[Reference – Minutes of the Technical Subcommittee meeting held on 06 July 2005, ICD-10 National Task Team]

DSN2121 Finding and a Routine X-ray

When a finding and a routine x-ray need to be indicated, the finding should be coded in the primary position and the routine x-ray would be coded in the secondary position.

Example:

When a routine chest ray reveals no abnormalities, code the NAD first followed by the chest x-ray:

PDX: Z03.9 Observation for suspected disease or condition, unspecified

SDX: Z01.6 Radiological examination, not elsewhere classified

[Reference – Minutes of the Technical Subcommittee meeting held on 06 July 2005, ICD-10 National Task Team]

DSN2122 After hours radiological investigations

After hours radiological investigations have been standardized with the use of **Z01.8 Other specified special examinations**

[Reference – Minutes of the Technical Subcommittee meeting held on 06 July 2005, ICD-10 National Task Team]

DSN2123 Posts

A post in dental terms is implanted in a tooth to attach, for example, a crown onto a tooth. A post may fracture due to metal fatigue, similar to a hip prosthesis (definition – Dr Neil Campbell).

The following codes may be used should a fracture occur:

PDX: T88.8 Other specified complications of surgical and medical care, not elsewhere classified

ECC if Sequela

SDX: Y88.2 Sequela of adverse incidents associated with medical devices in diagnostic and therapeutic use

ECC if not a sequela

SDX: Y84.8 Abnormal reaction / later complication: other medical procedures

[Reference – Minutes of the Technical Subcommittee meeting held on 06 July 2005, ICD-10 National Task Team]

DSN2124 Z–codes Invalid in the Primary Position

Category **Z37 Outcome of delivery** may not be used in the primary position.

[Reference – Minutes of the Technical Subcommittee meeting held on 06 July 2005, ICD-10 National Task Team]

DSN2125 Issues of Consent

a) If a patient is in a coma and cannot give consent for radiological intervention code as **R40.2 Coma, unspecified** or any other code indicating the signs and / or symptoms that are necessitating the investigation is appropriate for use.

b) If a minor requires radiological investigation for which he / she cannot give consent code as **Z01.6 Radiological examination, not elsewhere classified** is appropriate as per the indexing rules.

[Reference – Minutes of the Technical Subcommittee meeting held on 03 August 2005, ICD-10 National Task Team]

DSN2126 Repair of a Hearing Device

The condition requiring the hearing aid would be coded in the primary position, such as hearing loss e.g. **H91.0 Ototoxic hearing loss** followed by **Z46.1 Fitting and adjustment of hearing aid** in the secondary position.

[Reference – Minutes of the Technical Subcommittee meeting held on 03 August 2005, ICD-10 National Task Team]

DSN2127 Transport of Blood

Code **Z51.3 Blood transfusion without reported diagnosis** and the appropriate NHRPL code to represent the transport of blood.

[Reference – Minutes of the Technical Subcommittee meeting held on 15 February 2006, ICD-10 National Task Team]

DSN2128 Coding for Microbiology

A “R” code indicating abnormal findings can be used in the primary position as well as a “B” code or a code to indicate the organism identified can be used in the secondary position.

If no abnormalities were detected, the default code **Z03.9 Observation for suspected disease or condition, unspecified** can be used in the secondary position.

For routine pathology examination refer to DSN 2103 Routine Examination Pathology

[Reference – Minutes of the Technical Subcommittee meeting held on 15 March 2006, ICD-10 National Task Team]

DSN2129 Coding of Terminal Care

Terminal care is the care rendered for a patient who has ceased active treatment for their disease and now requires basic care during the final stages of their illness.

The primary diagnosis code should be the condition resulting in the patient requiring terminal care. The terminal care code should be coded as the secondary code.

Example:

Patient terminally ill with AIDS

PDX: B24 Unspecified human immunodeficiency virus [HIV] disease

SDX: Z51.5 Palliative care

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

DSN2130 Post Exposure Prophylaxis (PEP)

The reason requiring the administration of the prophylactic treatment should be coded.

Example 1:

Health care worker prescribed PEP. She sustained a needle stick injury to her finger following administration of an injection to a HIV positive patient in the hospital where she works.

PDX: S61.0 Open wound of finger(s) without damage to nail

SDX: W46.22 Contact with hypodermic needle, school, other institution and public administrative area, while working for income

Example 2:

Patient for PEP, information not disclosed to the pharmacy dispensing the PEP.

PDX: Z29.8 Other specified prophylactic measures

Guideline

The use of **Z20.6 Contact with and exposure to human immunodeficiency virus [HIV]** should only be used if there is clear documentation that the person was exposed to HIV.

[Reference – Minutes of the Technical Subcommittee meeting held on 12 September 2007, ICD-10 National Task Team]

Diagnosis Standard National – 22

Codes for special purposes (U00 – U99)

DSN2201 Valid U codes, unique to South Africa

The **U50.–** codes must accompany codes from A15, A17, A18, and A19 where bacteriological confirmation of aetiology has been established and site of disease is stated. These codes are to be used as additional codes.

U50 Drug resistant tuberculosis

U50.0 Multidrug resistant tuberculosis (MDR TB)

U50.00 Primary multidrug resistant tuberculosis (MDR TB)

U50.01 Secondary multidrug resistant tuberculosis (MDR TB)

U50.1 Drug resistant tuberculosis, resistance to isoniazid (INH) only

U50.10 Drug resistant tuberculosis, primary resistance to isoniazid (INH) only

U50.11 Drug resistant tuberculosis, secondary resistance to isoniazid (INH) only

U50.2 Drug resistant tuberculosis, resistance to rifampicin only

U50.20 Drug resistant tuberculosis, primary resistance to rifampicin only

U50.21 Drug resistant tuberculosis, secondary resistance to rifampicin only

U50.3 Drug resistant tuberculosis, resistance to isoniazid (INH) and rifampicin and any other anti-tuberculosis drug

U50.30 Drug resistant tuberculosis, primary resistance to isoniazid (INH) and rifampicin and any other anti-tuberculosis drug

U50.31 Drug resistant tuberculosis, secondary resistance to isoniazid (INH) and rifampicin and any other anti-tuberculosis drug

U50.4 Drug resistant tuberculosis, resistance to isoniazid (INH) and rifampicin and any drug not classified as an antituberculosis drug, including antibiotics, anti-leprotics, etc.

U50.40 Drug resistant tuberculosis, primary resistance to isoniazid (INH) and rifampicin and any drug not classified as an antituberculosis drug, including antibiotics, anti-leprotics, etc.

U50.41 Drug resistant tuberculosis, secondary resistance to isoniazid (INH) and rifampicin and any drug not classified as an antituberculosis drug, including antibiotics, anti-leprotics, etc.

U50.5 Extensively drug resistant tuberculosis (XDR TB), resistance to INH and rifampicin, and any fluoroquinolone plus capreomycin and/or kanamycin and/or amikacin

U50.50 Extensively drug resistant tuberculosis, primary resistance to INH and rifampicin, and any fluoroquinolone plus capreomycin and/or kanamycin and/or amikacin

U50.51 Extensively drug resistant tuberculosis, secondary resistance to isoniazid and rifampicin, and any fluoroquinolone plus one of: capreomycin and/or kanamycin and/or amikacin

U50.6 Extensively drug resistant tuberculosis (XDR TB), resistance to INH and rifampicin, and any fluoroquinolone plus other specified second-line injectable anti-TB drug

U50.60 Extensively drug resistant tuberculosis, primary resistance to INH and rifampicin, and any fluoroquinolone plus other specified second-line injectable anti-TB drug

U50.61 Extensively drug resistant tuberculosis, secondary resistance to INH and rifampicin, and any fluoroquinolone plus other specified second-line injectable anti-TB drug

U50.9 Drug resistant tuberculosis, drug unspecified

U50.90 Drug resistant tuberculosis, primary resistance to drug, unspecified

U50.91 Drug resistant tuberculosis, secondary resistance to drug, unspecified

[Reference – Minutes of the Technical Subcommittee meeting held on 01 June 2005, ICD-10 National Task Team]

The SA ICD-10 Coding Standards are to be used concurrently with the ICD-10 volumes and training material.

DSN2202 The use of U-codes

The following U codes for non-disclosure were reviewed by the WHO and found to be appropriate for our purpose.

U98 Non-disclosure

U98.0 Patient refusal to disclose clinical information

U98.1 Service Provider refusal to disclose clinical information

[Reference – Minutes of the Technical Subcommittee meeting held on 6 April 2005, ICD-10 National Task Team]

Coding Definitions

Current Injury

A current injury may be identified by the codes (S00 – T88) Injury, poisoning and certain other consequences of external causes.

A current injury is one for which the repair proceeding is yet to be completed. This includes multi-staged interventions.

An injury is considered current where it remains infected or inflamed and has not healed and requires continued treatment. Admissions are coded to the current injury codes (S00 – T88).

Old Injury

An old injury may be identified by the codes (M00-M99) or other appropriate codes. An old injury is one in which the repair has been completed or the injury has healed. However, following the repair, functionality has failed to return and continuing treatment is required.

[Reference – Final Document, ICD-10 implementation, August 2004]

Quick Reference Code Lists (QRC)

Quick Reference Code Lists (QRC) were developed by various Professional Bodies and Associations to assist their members with the implementation of ICD-10. The ICD-10 National Task Team reviewed the lists to ensure compliance with the WHO ICD-10 requirements. These lists were developed for Doctors, Allied and Support Health Professionals and **may under no circumstance be used by hospitals**, either in the Private or Public Healthcare Sectors.

As of the 1st of March 2007, the Task Team is no longer in a position to assist with the development or endorsement of any new QRC lists. The correct use of the ICD-10 coding tools together with training is being advocated as the most appropriate way to ensure ICD-10 codes are correctly interpreted and applied. All existing QRC's must be updated and version controls must be maintained accordingly by the owners of these lists.

Version 2 of the MIT (edition 3 of ICD-10) implemented on the 01st September 2007 may have an impact on existing QRC lists. These QRC lists must be updated to avoid rejection of claims.

[Reference – Circular no 31 of 2007, Council for Medical Schemes]

Routine

“Routine” in medical terms means “usual”.

[Reference – Minutes of the Technical Subcommittee meeting held on 05 April 2005, ICD-10 National Task Team]

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CAT	Computerised Axial Tomography
CMS	Council for Medical Schemes
COIDA	Compensation for Injuries and Diseases Act
DSN	Diagnosis Standard National
ECC	External Cause Code
GSN	General Standard National
HIV	Human Immunodeficiency Virus
ICD-10	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision
MIT	Master Industry Table
MRI	Magnetic resonance imaging
NAD	No Abnormalities Detected
NHRPL	National Health Reference Price List
NTT	National Task Team
PDX	Primary Diagnosis
PEP	Post Exposure Prophylaxis
QRC	Quick Reference Code Lists
RAF	Road Accident Fund
SDX	Secondary Diagnosis
URC	Update Reference Committee
WHO	World Health Organisation

References

ICD-10 National Task Team

Extracts from minutes of the Technical, Operational and Training Task Team meetings

The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM), Third Edition, Volumes 1 – 5

Australian Coding Standards, Volume 5, Third Edition

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Dorland's Medical Dictionary Twenty-third Edition