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 3 (as at March 2009)

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.

ICD-10 is a diagnostic coding standard that was adopted by the National Department of Health in 1996 as the national standard for South Africa. ICD-10 was implemented in July 2005 under the auspice of the National ICD-10 Implementation Task Team which is a joint task team between the National Department of Health and the Council for Medical Schemes. ICD-10 remains the responsibility of the National Department of Health. 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 – **G**eneral **S**tandard **N**ational
GSN00 Covers General Standards for Diseases
01 – A unique number allocated to the standard (the Standard Number)

GSN0101
GSN01 Covers General Standards related to Claims
01 – A unique number allocated to the standard (the Standard Number)

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)

Summary of changes made to the South African Coding Standards document

This section contains a summary of changes (additions, deletions and corrections) made to the South African Coding Standards document.

1. Correction to example at **C97 Malignant neoplasms of independent (primary) multiple sites, DSN**0201 **Neoplasm Coding**

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

Correction:
Multiple carcinomas
PDX: C97 Malignant neoplasms of independent (primary) multiple sites
M8010/3 Carcinoma NOS, primary site

[Correction, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, ICD-10 National Task Team]

2. Coding guideline added to the Pregnancy portion of the standards document

Guideline when submitting a claim for a breast pump
Code Z39.1 Care and examination of lactating mother should be used when a post natal nursing sister, midwife or lactation consultant supplies or provides a patient with a breast pumps.

Code Z76.8 Persons encountering health services in other specified circumstances should be used by pharmacies or other supplies that sell and rent breast pump.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, ICD-10 National Task Team]

3. Coding guideline added to **GSN**0015 **Sequelae (Late Effects)**

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.

Guideline
Sequelae of external causes of morbidity and mortality (Y85 – Y89) must be coded in addition to any codes for Sequelae of injuries, of poisoning and of other consequences of external causes (T90 – T98).

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, ICD-10 National Task Team]

4. Coding guideline added to **DSN**0901 **Coding of the Circulatory System**

Coding impairment of heart muscle
Clinical coders should request more information when the description "impairment of heart muscle" is documented. "Impairment of heart muscle" should be coded to I51.5 if no further information is available.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, ICD-10 National Task Team]

5. Coding guideline added to DSN11 Diseases of the digestive system

Coding of degenerative leiomyopathy
Clinical coders should request more information when the description "degenerative leiomyopathy" is documented. Degenerative leiomyopathy will be coded like a syndrome. Refer to **GSN**0013 **Coding of Syndromes**.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, ICD-10 National Task Team]

6. Coding Standard added to the Pregnancy portion of the standards document

Coding of HELLP syndrome which resulted in a ruptured liver
Sequence O14.1 Severe pre-eclampsia as the primary diagnosis with an additional code O26.6 Liver disorders in pregnancy, childbirth and the puerperium as there is no specific code for non-traumatic rupture of the liver.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, ICD-10 National Task Team]

7. Coding Standard added to DSN 20 External causes of morbidity and mortality (V01 – Y98)

DSN2002 **Coding for Compensation for Occupational Injuries and Diseases Act (COIDA)**

In terms of the Compensation for Occupational Injuries and Diseases Act no.130 of 1993 (COIDA) an employee would not be covered by this legislation if involved in an accident on his way to work or traveling home from work.

This exception to this is found in section 22(5) of (COIDA) which states that an employee would be covered under the following circumstances:

- Employee is transported free of charge to and from work;
- Vehicle driven by employer or employee;
- Vehicle specially provided for this purpose.
- This would for example be a "staff bus."

External Cause Codes (ECC) – 5th Character – Activity

0 – While engaged in sports activity
This excludes sports activities which include - paid work (manual) (professional), work for salary, bonus and other types of income.

1 – While engaged in leisure activities
Excludes: sports activities (0)

2 – While working for income
Paid work (manual) (professional)

Transportation (time) to and from such activities i.e. (work activities) e.g. a medical representative traveling from work to a client or a health practitioner traveling from a patient back to his/her practice or hospital etc.
Work for salary, bonus and other types of income

3 – While engaged in other types of work
NB – Duties for which one would not normally gain an income

4 – While resting, sleeping, eating or engaging in other vital activities

8 – While engaged in other specified activities

9 – During unspecified activity

The use of the 5th Character in the ECC

2 – While working for income (meaning as an employee).
Paid work (manual) (professional) (This includes professional sports)
Transportation (time) to and from such activities i.e. (work activities)
Work for salary, bonus and other types of income

In terms of COIDA it would be therefore be more correct to say whilst working as an employee.

Footnote:

1. The definition of an employee in terms of COIDA reads as follow "employee means a person who has entered into or works under a contract of service of apprenticeship or learnership, with an employer, whether the contract is express or implied, oral or in writing and whether **remuneration** is calculated by time or by work done, **or is in cash or kind.**"
2. The Commissioner does not regard an injury to a professional sport person as an injury in terms of COIDA. The reason being that the employer does not have control over such a person.
3. In terms of the Compensation for Occupational Injuries and Diseases Act no.130 of 1993 (COIDA) an employee would not be covered by this legislation if involved in an accident on his way to work or traveling home from work. This exception to this is found in section 22(5) of (COIDA) which states that an employee would be covered under the following circumstances:
    - Employee is transported free of charge to and from work;
    - Vehicle driven by employer or employee ;
    - Vehicle specially provided for this purpose.
4. The person traveling from home to a client will be considered in terms of COIDA if his job description states that he has to see clients.

COIDA Definitions

- DOMESTIC EMPLOYER
  In terms of the definition of an employee, domestic employees are excluded from COIDA. This would mean that if a domestic employee can show that he was injured through the negligence of his employer he would be able to sue his employer. This liability is normally covered in a person's Household Insurance Policy under "Public Liability". Cases of domestic employees suing their employers have been reported in the past. The Commissioner indicated about two years ago that his intention is to include these employees under COIDA, however this has not materialised yet.

- CONTRACTUAL WORKER
  An employer has to declare at the end of every year what salary was paid to full time employees and contracted employees. These employees would therefore be covered by COIDA.

- SELF EMPLOYED
  An employer can only register in terms of COIDA when he employs one or more persons. A self employed person is therefore not covered by COIDA.

- PROFESSIONAL SPORTS
  As indicated previously persons participating in professional sports are not covered.

- EMPLOYEE
  "employee means a person who has entered into or works under a contract of service of apprenticeship or learnership, with an employer, whether the contract is express or implied, oral or in writing and whether **remuneration** is calculated by time or by work done, **or is in cash or kind**."

Footnote:
All the above will be identified by the 5th character 2.
Special attention must be given as to when payment will be made by various payers such as COIDA, Insurances etc.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, ICD-10 National Task Team]

8. Addition to **DSN**1004 **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 1:
Patient admitted with COPD and Emphysema
PDX: J44.9 Chronic obstructive pulmonary disease, unspecified
SDX: J43.9 Emphysema, unspecified

Example 2:
Patient admitted with chronic bronchitis with emphysema
PDX: J44.8 Other specified chronic obstructive pulmonary disease

Rules on assignment
Take note of the inclusion and exclusion notes below J43 and J44 in the tabular list (volume 1). Emphysema with chronic bronchitis will be coded to J44.–

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

9. Addition to **DSN**0302 **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 haemophilliac
PDX: D66 Hereditary factor VIII deficiency
SDX: R04.0 Epistaxis

Guideline
Sometimes an additional code is required to fully describe a diagnosis with a manifestation. Certain symptoms that represent important problems in medical care in their own right should therefore be coded in addition to the underlying condition. Refer to point (f) below chapter XVIII in the tabular list (volume 1).

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

10. Addition and amendment to **Guidelines when using sign and symptom codes e.g. R-codes**

- The paragraph below will be removed from the South African ICD-10 coding standards document version 3.

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.

- The following paragraph will be added to the South African ICD-10 coding standards document version 3.

'Sign and symptom' codes that begin with the letter 'R' are used if no definite diagnosis has been established at the end of an episode of health care or if a patient is treated symptomatically at a primary health care level. The information that permits the greatest degree of specificity and knowledge about the condition that necessitated care or investigation should be recorded. This should be done by stating a symptom, abnormal finding or problem, rather than qualifying a diagnosis as "possible", "questionable" or "suspected", when it has been considered but not established.

Example 1:
Patient presenting with photophobia, fever and neck stiffness. Diagnosis – Meningitis
Code the definitive diagnosis – Meningitis
PDX: G03.9 Meningitis, unspecified

Example 2:
Patient admitted with sickle-cell crisis and acute chest syndrome.
PDX: D57.0 Sickle-cell anaemia with crisis
Acute chest syndrome is an integral part of sickle cell crisis and therefore not coded separately.

You do not have to code the symptoms. Therefore signs and / or symptoms inherent to a diagnosis should not be assigned in addition to the code assigned for the specified diagnosis unless these represent important problems in medical care in their own right.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]
[Amendment, Reference – Minutes of the Technical Subcommittee meeting held on 05 February 2009, ICD-10 National Task Team]

11. Addition to **DSN**1905 **Coding Injuries**

Guidelines when coding injuries
1. The S-section is used for coding different types of injuries related to single body regions and the T-section covers injuries to multiple or unspecified body regions, as well as poisoning and other consequences of external causes.

2. Where multiple sites of injury are specified in the titles, the word "with" indicates involvement of both sites and the word "and" indicates involvement of either or both sites

4. When coding from chapter XIX, always use an external cause code in addition to codes from chapter XIX

Example:
Fracture of vault of skull with concussion without open intracranial wound. This occurred when the patient who was the driver of his car, collided with another car in a traffic accident, while going on holiday
PDX: S06.00: Concussion without open intracranial wound
SDX: S02.00: Fracture of vault of skull, closed
SDX: V43.51: Car occupant injured in collision with car, pick-up truck or van, driver, traffic accident, while engaged in leisure activity

5. The word “optional” in the ICD-10 volumes has been replaced by the word “mandatory” in South African coding environment.

Example:
Refer to note below S06 in the tabular list (volume 1)
“The following subdivisions are provided for optional use in a supplementary character position, where it is not possible or not desired to use multiple coding”

6. A fracture not indicated as closed or open should be classified as closed
Example:
A fracture of the mandible
PDX: S02.60: Fracture of mandible, closed

7. An intra-cavity injury not stated as open or closed, should be classified as closed

Example:
Traumatic pneumothorax
PDX: S27.00 Traumatic pneumothorax, without open wound into thoracic cavity

Sequencing rules when coding injuries
1. Code the internal injury as the main condition for internal injuries recorded with superficial injuries and / or open wounds.

Example:
Patient sustained an injury to the lung. Stab wound to back wall of chest.
PDX: S27.31 Other injuries of lung, with open wound into thoracic cavity
SDX: S21.2 Open wound of back wall of thorax
SDX: X99.99 Assault by sharp object, unspecified place, during unspecified activity

2. Code the intracranial injury as the main condition for fractures of skull and facial bones with associated intracranial injury.

Example:
Closed fracture of vault of skull with concussion without open intracranial wound
PDX: S06.00 Concussion, without open intracranial wound
SDX: S02.00 Fracture of vault of skull, closed

3. Code intracranial haemorrhage as the main condition for intracranial haemorrhage recorded with other injuries to the head.

Example:
Patient admitted with a fracture of the skull with a subdural haemorrhage following a fall from the balcony of his apartment.
PDX: S06.50 Traumatic subdural haemorrhage, without open intracranial wound
SDX: S02.90 Fracture of skull and facial bones, part unspecified, closed
SDX: W13.09 Fall from, out of or through building or structure, home, during unspecified activity

4. Code the fracture as the main condition for fractures recorded with open wounds of the same location.

Example:
Fracture shaft of humerus with an open wound of the same site.
S42.31 Fracture of shaft of humerus, open

[Reference Volume 2, First Edition, page 123 or Second Edition, page 129]

Multiple Injury coding rule
When multiple injuries are recorded, code all the individual injuries sequencing the most life threatening condition in the primary position or as described in the South African definition of the primary diagnosis.

For multiple injuries of the same anatomic site, organ or body region, list each injury individually.

Example 1:
Patient sustained multiple fractures to the lower leg. Open fracture of lower end of tibia and fibula. Closed fracture of the lateral malleolus. This occurred when the patient fell out of a tree, at home, while gardening
PDX: S82.31: Fracture of lower end of tibia, open (this includes fracture of fibula)
SDX: S82.60: Fracture of lateral malleolus, closed
SDX: W14.03: Fall from tree, home, while engaged in other types of work (ECC)

Guideline
ICD-10 does not make provision for bilateral fractures, e.g. closed bilateral fracture of shaft of humerus. Assign the code for the fracture once if the fractures are the same.
This rule will not apply to providers who are required to provide codes at a line level.

If the fractures differ and one fracture is open and the other is closed. Assign individual codes for each fracture and sequence appropriately.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

5. The definitions of current and old injuries have been moved to **DSN**1905 **Coding Injuries**. There is an addition to the definition of current injury.

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).

Exception:
This will not apply when the injury does not heal in cases of osteomyelitis, malunion and nonunion etc. In this instance, assign the appropriate code from the musculoskeletal section with the appropriate 4^{th} and 5^{th} character codes.

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]

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

12. Addition to **DSN**1901 **Poisoning, Overdose and Adverse Effects**

Guideline
- Assign a code for each drug if multiple drugs documented.
- Assign a code for each active ingredient of a combination drug sequencing the one with the highest strength in the absence of detailed information.
- Code the 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 1:
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

Example 2:
Child admitted for poisoning. Accidentally ingested myprodol which was left on the kitchen table at home. Myprodol [active ingredients: Ibuprofen 200mg, Paracetamol 250mg and Codeine Phosphate 10mg.

PDX: T39.1 Poisoning: 4-aminophenol derivatives
SDX: T39.3 Poisoning: other nonsteroidal anti-inflammatory drugs [NSAID]
SDX: X40.09 Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, home, during unspecified activity
SDX: T40.2 Poisoning: other opioids
SDX: X42.09 Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, home, during unspecified activity

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

13. **DSN**2133 **Coding results of HIV tests** has been added
Code positive serology (Elisa or Western Blot) for HIV-1 antibody to **R75 Laboratory evidence of human immunodeficiency virus [HIV]**
Code negative serology to **Z01.7 Laboratory examination**
Code positive PCR qualitative tests for HIV-1 Ag to **R75 Laboratory evidence of human immunodeficiency virus [HIV]**
Code negative PCR qualitative tests for HIV-1 Ag to **Z01.7 Laboratory examination**
Code PCR HIV VIRAL Load to **Z01.7 Laboratory examination**
Code PCR HIV Drug Resistance genotyping to **Z01.7 Laboratory examination**

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

14. **DSN**1305 **Site of musculoskeletal involvement** has been added

Code each site individually when multiple site involvement of the musculoskeletal system is documented. The 5th character option of '0' is not to be assigned if multiple sites are listed by the Physician.

Example:
Juvenile rheumatoid arthritis of the shoulder, hand and ankle
PDX: M08.01: Juvenile rheumatoid arthritis, shoulder region
SDX: M08.04: Juvenile rheumatoid arthritis, hand
SDX: M08.07: Juvenile rheumatoid arthritis, ankle and foot

M08.00 Juvenile rheumatoid arthritis, multiple sites cannot be used in this situation

This code can only be assigned if the Physician does not list the individual sites, and states for e.g. Juvenile rheumatoid arthritis, multiple sites

If there is multiple involvement of a single joint, assign an appropriate code if an option is available for e.g. tear of meniscus [R] knee, involving anterior and posterior cruciate ligament.

If there is bilateral involvement, assign an appropriate code if an option is available.

Example:
Bilateral primary arthrosis of the knee
Correct code: M17.0: Primary gonarthrosis of knee

Refer to the excludes note under M15 Polyarthrosis
Excludes: bilateral involvement of a single joint (M16 – M19)

Multiple involvement of a single joint may lead to the patient having symptoms in multiple areas of the body, this however does not mean that 5th character option "0" "multiple sites" must be assigned or that the multiple sites of the body that are affected should be coded.

Example:
Ankylosing spondylitis of the thoracic region with pain radiating to the lower back, cervical region, and upper limbs

PDX: M45.X4 Ankylosing spondylitis, thoracic region

You can assign additional codes for the lower back pain, cervicalgia and pain in upper limbs if these represent important problems in the medical care rendered.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 04 February 2009, ICD-10 National Task Team]

15. Addition to **GSN**0006 **Level of Coding**
The word "optional" in the ICD-10 volumes has been replaced by the word "mandatory" in South African coding environment.

Example: refer to note below S06 in the tabular list (volume 1)
"The following subdivisions are provided for optional use in a supplementary character position, where it is not possible or not desired to use multiple coding"

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

16. **DSN**1501 **Pregnancy with abortive outcome, DSN**1502 **Pregnancy, DSN**1503 **Labour and Delivery** and **DSN**1504 **Puerperium** have been added.

DSN1501 **Pregnancy with abortive outcome**

Abortion
An abortion is generally defined as the delivery or loss of the products of conception up to and including the twentieth (20th) week of gestation.

Refer to the Act No. 1 of 2008: Choice on Termination of Pregnancy Amendment Act, 2008.

003 Spontaneous abortion
Spontaneous abortions occur without any instrumentation. They may be threatened, inevitable, incomplete or complete.

O20.0 Threatened abortion
Threatened abortion is any bleeding or cramping of the uterus in the first twenty two weeks of pregnancy.

Inevitable abortion is an abortion that is bound to happen.

If part of the products of conception are retained the abortion is **incomplete**.

If all of the products of conception are passed and the uterus has contracted towards normal size and the cervix has closed, the abortion is **complete**.

Induced abortions are those done for medical or elective reasons. When an abortion is done for a medical reason, assign a code from the appropriate category in the primary position to indicate the reason for the abortion and an additional code from category O04 Medical abortion.

Example 1:
Patient admitted for an elective abortion at 12 weeks.
PDX: O04.9 Medical abortion, complete or unspecified, without complication

Example 2:
Patient admitted for a medical abortion at 22 weeks of gestation due to rhesus isoimmunisation
PDX: O36.0 Maternal care for rhesus isoimmunization
SDX: O04.9 Medical abortion, complete or unspecified, without complication

Should the outcome of the delivery be a live born infant, then the primary diagnosis code will remain the reason for the medical abortion. An additional code from category O04 Medical abortion will not be assigned.

Example:
Patient admitted for a medical abortion at 22 weeks of gestation for suspected damage to foetus following a medical procedure
PDX: O35.7 Maternal care for (suspected) damage to fetus by other medical procedures
SDX: Z37.0 Single live birth

O02.1 Missed abortion
Missed abortion occurs when the foetus dies and is retained in utero.

Septic abortion develops when the contents of the uterus become infected before, during or after an abortion.

Habitual abortion is the occurrence of three or more consecutive spontaneous abortions.

O05 Other abortion
Other abortion includes illegally induced abortion – the illegal interruption of pregnancy by any means.

O06 Unspecified abortion
Unspecified abortion indicates a direct inadvertent abortion i.e. where the patient undergoes uterine surgery (e.g. hysterectomy or dilatation and curettage) and the pregnancy is therefore terminated.

O07 Failed attempted abortion
Failed attempted abortion is the failure or attempted induction of abortion – legal or illegal. This means that the foetus has not been removed.

O00 Ectopic Pregnancy
Development of the embryo outside the uterine cavity, also called extra-uterine pregnancy.

Coding of Pregnancy with abortive outcome (O00 – O008)

Episode as described in categories O00 – O008
The period of admission for treatment until discharge

Complication following abortion and ectopic and molar pregnancy, current episode
This is when the complication occurs during the same episode of care following abortion and ectopic and molar pregnancy.

Complication of abortion, current episode (O00 – O002)
Use an additional code from category O08 Complication following abortion and ectopic and molar pregnancy to indicate any associated complications for categories O00 – O002.
An additional code is required for the classification of the specific complication if the O08._ code description is not specific.

Example:
Patient admitted with a rupture tubal pregnancy resulting in salpingitis
PDX: O00.1 Tubal pregnancy
SDX: O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy
SDX: N70.9 Salpingitis and oophoritis, unspecified

Complication of abortion, current episode (O03 – O06)
Assign the appropriate fourth character code for categories O03 – O06 for complications occurring during the same episode of care following abortion.
An additional code is required for the classification of the specific complication if the fourth character code description is not specific.
Use an additional code from category O08 Complication following abortion and ectopic and molar pregnancy to indicate any associated complications for categories O00 – O06 when they have a fourth character of .3 or .8.

Example 1:
Patient admitted for a complete medical abortion resulting in pelvic peritonitis
PDX: O04.5 Medical abortion, complete or unspecified, complicated by genital tract and pelvic infection
SDX: N73.5 Female pelvic peritonitis, unspecified

Therefore O08 Complications following abortion and ectopic and molar pregnancy should not to be used as additional codes for O03 – O07 except when they have a fourth character of .3 or .8.

Example 2:
Patient admitted for a complete medical abortion. Developed post-operative shock.
PDX: O04.5 Medical abortion, complete or unspecified, complicated by genital tract and pelvic infection
SDX: O08.3 Shock following abortion and ectopic and molar pregnancy

O07 Failed attempted abortion
Assign the appropriate fourth character code for category O07 for complications occurring during the same episode of care following abortion.
An additional code is required for the classification of the specific complication if the fourth character code description is not specific.
Use an additional code from category O08 Complication following abortion and ectopic and molar pregnancy to indicate any associated complications for category O07 when there is a fourth character of .3 or .8.

Subsequent Episode
Period after discharge or previous treatment

Complication following abortion and ectopic and molar pregnancy, subsequent episode
The O08 Complication following abortion and ectopic and molar pregnancy category of codes should be used in the **primary position** when the complication of pregnancy with abortive outcome occurs as a subsequent episode i.e. when the patient has been discharged or treated previously following an abortive outcome of pregnancy and is re-admitted with complications.

The exception to this rule is when the patient is admitted with retained products of conception which will be coded to the O03 – O06 category with the appropriate fourth character code of .0 – .4. In this instance it is not a complication of the abortion.
(Incomplete abortion includes retained products of conception following abortion)

Example 1:
Patient admitted for Oophoritis following a spontaneous abortion.
PDX: O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy
SDX: N70.9 Salpingitis and oophoritis, unspecified
Example 2:
Patient had a therapeutic abortion and subsequently admitted with retained products of conception.
PDX: O04.4 Medical abortion, incomplete, without complication

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

DSN1502 **Pregnancy**

Primigravida
An elderly Primigravida is generally related to a primigravida who is 35 years and older.
A young Primigravida is generally related to a primigravida who is 18 years and younger.

Coding Pre-existing hypertension complicating pregnancy, childbirth and the puerperium
Guideline
An additional code may be assigned in order to describe the patient's condition.
Example:
Patient has pre-existing hypertensive renal disease with renal failure.
PDX: O10.2 Pre-existing hypertensive renal disease complicating pregnancy, childbirth and the puerperium
SDX: I12.0 Hypertensive renal disease with renal failure

HELLP syndrome (O14.1)
A syndrome featuring a combination of "H" for haemolysis "EL" for elevated liver enzymes and "LP" for low platelet count. The HELLP syndrome is a recognised complication of pre-eclampsia and eclampsia (toxaemia) of pregnancy.

Coding of HELLP syndrome which resulted in a ruptured liver
Sequence O14.1 Severe pre-eclampsia as the primary diagnosis with an additional code O26.6 Liver disorders in pregnancy, childbirth and the puerperium as there is no specific code for non-traumatic rupture of the liver.

Early Pregnancy
Early pregnancy is considered to be before twenty-two (22) completed weeks of gestation therefore < twenty-two (22) weeks pregnant.

Late pregnancy
Late pregnancy is considered to be after twenty-two (22) completed weeks of gestation therefore = and > twenty-two (22) weeks pregnant.

Haemorrhage in early pregnancy
Haemorrhage in early pregnancy will be coded to O20._ Haemorrhage in early pregnancy.
Pregnancy
– complicated by
– – haemorrhage
– – – before 22 completed weeks of pregnancy

Antepartum haemorrhage
Antepartum haemorrhage will therefore be considered to be bleeding occurring after 22 completed weeks of gestation and should be coded to category O46 Antepartum haemorrhage, not elsewhere classified.

Vomiting in early pregnancy
Vomiting in early pregnancy will be coded to O21.0 Mild hyperemesis gravidarum and to O21.1 Hyperemesis gravidarum with metabolic disturbance if further complicated by metabolic disturbance.

Vomiting in late pregnancy
Vomiting in late pregnancy will be coded to O21.2 Late vomiting of pregnancy.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

DSN1503 **Labour and Delivery**

Antenatal
Prenatal, existing or occurring before birth.

Antepartum
Occurring before parturition or childbirth.

Multiple gestation (O30)
This category should be assigned as the primary diagnosis when no other condition classifiable to Chapter XV is present. This category should be as an additional code when assigning other codes from chapter XV.

Example:
Elective caesarean section for twin pregnancy. Both liveborn.
PDX: O30.0 Twin pregnancy
SDX: O84.2 Multiple delivery, all by caesarean section
SDX: Z37.2 Twins, both liveborn

Maternal care for known or suspected malpresentation, disproportion and abnormality of pelvic organs (O32 – O34)
When a malpresentation of foetus, disproportion or abnormality of maternal pelvic organs is present before the onset of labour and a procedure e.g. a caesarean section is carried out, assign a primary diagnosis code from categories O32 Maternal care for known or suspected malpresentation of fetus or O33 Maternal care for known or suspected disproportion or O34 Maternal care for known or suspected abnormality of pelvic organs

Example:
Patient admitted for breech presentation. Elective caesarean section carried out. Delivered a healthy live born infant.
PDX: O32.1 Maternal care for breech presentation
SDX: O82.0 Delivery by elective caesarean section
SDX: Z37.0 Single live birth

When a malpresentation of foetus, disproportion or abnormality of maternal pelvic organs is diagnosed during labour and requires medical care, assign a primary diagnosis code from categories O64 Obstructed labour due to malposition and malpresentation of fetus or O65 Obstructed labour due to maternal pelvic abnormality or O66 Other obstructed labour

Example:
Obstructed labour due to cephalopelvic disproportion. Emergency caesarean section. Delivered a healthy liveborn infant.
PDX: O65.4 Obstructed labour due to fetopelvic disproportion
SDX: O82.1 Delivery by emergency caesarean section
SDX: Z37.0 Single live birth

Maternal care for known or suspected foetal problems
Guideline
Poor / lack of foetal movement should be coded to O36.8 Maternal care for other specified fetal problems.

False Labour
Intermittent non-productive muscular contractions of the womb (uterus) during pregnancy, most commonly in the last two months before full term. These contractions are non-productive in the sense that they do not produce any flattening (effacement) or dilation (opening up) of the cervix.

Premature / Preterm Labour
Labour occurring between the twentieth and the thirty-seventh completed weeks of pregnancy.

O60.0 Preterm labour without delivery
Labour occurring before 37 completed weeks of pregnancy, without delivery

O60.1 Preterm labour with preterm delivery
Labour occurring before 37 completed weeks of pregnancy with a delivery

O60.2 Preterm labour with term delivery
Labour occurring before 37 completed weeks with delivery after 37 completed weeks of pregnancy

Example:
Patient was admitted into hospital at 30 weeks of gestation due to premature labour. Labour was delayed by pitocin therapy for two days. On day three, fetal distress was noted and an emergency caesarean section was performed and a live born infant was delivered.
PDX: O68.9 Labour and delivery complicated by fetal stress, unspecified
SDX: O60.1 Preterm labour with preterm delivery
SDX: O82.1 Delivery by emergency caesarean section
SDX: Z37.0 Single live birth

Labour may be divided into four stages:
The first stage (cervical dilation) begins with the onset of regular uterine contractions and ends when the os is completely dilated.
The second stage extends from the end of the first stage until the expulsion of the infant is completed.
The third stage extends from the expulsion of the child until the placenta and membranes are expelled.
The fourth stage denotes the hour or two after delivery when the uterine tone is established.

Prolonged Labour
Labour prololonged beyond the ordinary 18-hour limit.

1st stage of labour
Poor prognosis in the latent phase of labour
- Latent phase is prolonged when it exceeds 8hrs

Poor prognosis in the active phase of labour
- Labour is prolonged if the cervix dilates at a rate of less than 1 cm/hr.

2nd stage of labour
Poor prognosis
- Foetal head has not descended onto the pelvic floor after 2 hrs of full dilatation.
- If delivery has not occurred after 45 minutes of pushing in a nullipara or 30 minutes of pushing in a multipara.

Delivery (O80 – O84)
Single spontaneous delivery (O80)
This category of codes can only be used for a normal delivery when no abnormality or complication related to the delivery is classifiable elsewhere in chapter XV or when no instrumentation or manipulation is used during the delivery.

Example:
Patient delivered a healthy infant following a spontaneous vertex delivery.
PDX: O80.0 Spontaneous vertex delivery
SDX: Z37.0 Single live birth

Z37 Outcome of Delivery
A code from category Z37 must be assigned on the mother's record to indicate the outcome of the delivery.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

DSN1504 **Puerperium**

Postpartum
After childbirth or after delivery.

Puerperium
The period from the end of the third stage of labour until involution of the uterus is complete, usually lasting three to six weeks.

Puerperial Sepsis
An infectious, sometimes fatal, type of septicaemia with fever, associated with childbirth. The focus of infection is the uterus and etiologic agent is frequently a streptococcus.

Post Partum Haemorrhage
Primary post partum haemorrhage is blood loss > 500mls in the first 24 hours after delivery or as a visibly excessive blood loss after delivery.

Secondary post partum haemorrhage is a passage of fresh blood or clots more than 24 hours after delivery.

Admission for post partum care
Assign Z39.0 as the primary diagnosis when a patient is admitted after delivery in the ambulance or transferred from the hospital where she delivered to another hospital for post partum care and there are no complications.

Example:
Patient admitted into hospital following a spontaneous delivery of a live born infant in the ambulance.
PDX: Z39.0 Care and examination immediately after delivery

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

17. Addition of footnote to **DSN**2201 **Valid U codes, unique to South Africa**
The 5th character indicates whether drug resistance is primary or secondary as follows:
0 indicates Primary resistance (transmission of a resistant strain, not previously diagnosed or treated)
1 indicates Secondary resistance (previously diagnosed and treated, partially treated)

Reference: Document compiled by Nelson Nagoor, Igolide Health Networks, published on the PHISC website http://www.dhsolutions.co.za/phisc/

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

18. Correction to the Introduction on the SA ICD-10 Coding Standards document.
The National Health Information System of South Africa (NHISSA) has been replaced by National Department of Health (NDoH).

ICD-10 is a diagnostic coding standard that was adopted by the National Department of Health in 1996 as the national standard for South Africa. ICD-10 was implemented in July 2005 under the auspice of the National ICD-10 Implementation Task Team which is a joint task team between the National Department of Health and the Council for Medical Schemes. ICD-10 remains the responsibility of the National Department of Health.

- The above paragraph will replace the introduction on the SA ICD-10 Coding Standards document.
- This will be added to the South African ICD-10 coding standards document version 3.

[Correction, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]
[Correction, Reference – Minutes of the Technical Subcommittee meeting held on 04 February 2009, ICD-10 National Task Team]

19. Descriptions to DSN2201 and DSN2202 have been amended.
DSN2201 **Valid U codes, unique to South Africa** changed to **DSN**2201 **Drug resistant tuberculosis**
DSN2202 **The use of U-codes** changed to **DSN**2202 **U98 Non-disclosure**

[Correction, Reference – Minutes of the Technical Subcommittee meeting held on 04 February 2009, ICD-10 National Task Team]

20. A separate section for the General Standards related to Claims has been added.

GSN0101
GSN – **G**eneral **S**tandard **N**ational
GSN01 Covers General Standards related to Claims
0101 – A unique number allocated to the standard (the Standard Number)

GSN0101 **Mandatory Inclusion of ICD-10 Codes on Claims** replaces **GSN**0003 **ICD-10 Codes on Claims**.
GSN0102 **Submission of Claims** replaces **GSN**0004 **Submission of claims**.

The following standards have been added:
GSN0103 **Paper and Electronic Claims containing ICD-10 Codes**
GSN0104 **Paper Claims containing ICD-10 Codes**
GSN0105 **Electronic Claims containing ICD-10 Codes**

GSN0101 **Mandatory Inclusion of ICD-10 Codes on Claims**

1. The requirement for all health care providers, diagnosing and non-diagnosing, to **indicate the diagnosis(es) for each medical service rendered** on all claims submitted to a medical scheme or provided to a member for claim(s) submission to a medical scheme has been defined as per the *Regulations to the Medical Schemes Act* published in Government Gazette No. 20556 of October 1999.

2. Providing a diagnostic code on claims is not limited to health care providers in **private practice**, therefore rendering their own claims. Health care providers working within the **public health sector** are also required to provide ICD-10 diagnostic codes.

3. All ICD-10 diagnostic coding must be performed as per the **World Health Organisation's official rules and conventions**.

4. South Africa will continue to use the ICD-10 diagnostic code schema as the **National Standard** for the foreseeable future.

5. In any situation in which a definitive diagnosis is not made, a **sign and / or symptom code** would be appropriate for use.

6. In the instance where the first health care provider treating the patient and that of the second health care provider 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 health care provider**s, for a number of reasons.

7. **Matching the diagnosis and treatment** should not become prescriptive in nature. It will be up to each individual medical scheme to profile health care providers using treatment that differs from the norm.

[Reference – Final Document, ICD-10 implementation, August 2004 and Circular 28 of 2007, Council for Medical Schemes]
GSN0101 **Mandatory Inclusion of ICD-10 Codes on Claims** replaces **GSN**0003 **ICD-10 Codes on Claims**
[Correction, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

GSN0102 **Submission of Claims**

1. **Claims submitted by Hospitals** must have the ICD-10 code(s) specified at the highest level i.e. header level or level 1. This means that ICD-10 codes do not have to be specified at line item level (detailed service items).

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

3. **Claims containing referring health care provider information and ICD-10 code(s)** (non-hospital) must indicate the referring provider's diagnostic codes but not at the line item level linked to procedural codes. Rather, the provider's details (name and surname, PCNS number, professional council number) and accompanying diagnoses must be presented at a higher summary level.

   To accommodate claims by multiple treating health care providers within a group, association or partnership practice, it is necessary to allow for **multiple referring provider** details as well as their respective ICD-10 codes. In such cases, the referring provider's details and ICD-10 codes would need to be explicitly linked to the relevant treating service provider referred to within that claim and may require that the referring provider's information and diagnoses be specified in some place other than at the "header" of the claim. For instance, the claim may allow for summary sections containing treating service provider details, referring service provider details and ICD-10 codes applicable to a series of line items and whenever any of the diagnoses by the treating service provider, referring service provider or referring service provider change for a set of lines, a new summary section must be inserted into the claim.

   Therefore, unless the claim explicitly denotes a set of ICD-10 codes as those supplied by a specific referring service provider linked to a specific treating service provider elsewhere in the claim (as described above), any "header level" ICD-10 codes which may be present will be assumed to be supplied by the referring service provider and will be applicable to all services rendered on the specific claim.

   While the population of the referring service provider's information and diagnostic code(s) into the appropriate field is not mandatory, it must be noted that the **existence of this field is mandatory**. All parties are therefore requested to ensure that fields containing referral diagnoses data are not discarded in the transmission of data to or at the medical scheme or administrator.

4. When **Dental Technician Laboratories** submit their own claims for reimbursement, these practices need to use the same principle as the referring health care providers by supplying the dentist or dental specialist's details and diagnostic codes as referral information.

[Reference – Final Document, ICD-10 implementation, August 2004 and Circulars 19 and 28 of 2007, Council for Medical Schemes]
GSN0102 **Submission of Claims** replaces **GSN**0004 **Submission of claims**
[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

GSN0103 **Paper and Electronic Claims containing ICD-10 Codes**

1. Provision must be made for a maximum of ten (10) ICD-10 codes per line item.

2. The functionality of **capturing ICD-10 codes** is in the domain of the Practice Management Application (PMA) used by the service provider.

3. **Submission of three-character ICD-10 codes** excludes the dot / full stop. For example code T16:

   Incorrect submission: T16**.**
   Correct submission: T16

4. **Submission of extended character ICD-10 codes** includes the dot / full stop. For example code K35.9:

Incorrect submission: K359
Correct submission: K35.9

5. Using **ditto characters (")** to indicate repeated diagnoses codes is not allowed on any claim.

6. Submission of ICD-10 codes on **only the first line of a multi-line claims** does not meet with legislative requirements.

7. It is inappropriate for service providers and / or medical schemes / administrators to **assume or flood down ICD-10 codes** against claim lines that do not have the actual ICD-10 code(s) clearly indicated by the treating service provider.

8. ICD-10 code(s) must be claimed **without descriptions** in order to maintain a patient's privacy and confidentiality.

9. **No spaces are allowed within ICD-10 codes** (the underscore _ used in the following example represents a space).

   Incorrect submission: M79._20/I15._0/K35._9
   Correct submission: M79.20_/_I15.0_/_K35.9

10. **No hyphens are allowed within ICD-10 codes**.

    Incorrect submission: M79-20/I15-0/K35-9
    Correct submission: M79.20_/_I15.0_/_K35.9

11. **No brackets are allowed within ICD-10 codes**.

    Incorrect submission: (M79.20)(I15.0)(K35.9)
    Correct submission: M79.20_/_I15.0_/_K35.9

12. **No indication of primary or secondary diagnosis** is required. The sequence will infer the primary diagnosis.

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

[References –Circular 36 of 2005 and 19 of 2007, Council for Medical Schemes, Minutes of the Technical Sub-committee meeting held on 12 September 2007, ICD-10 National Task Team.]
[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

GSN0104 **Paper Claims containing ICD-10 Codes**

1. If an ICD-10 code cannot be accommodated on the same printed line on a claim, then it will be recognized as a roll-over or content wrap if it is on the **line directly below** the description of the rendered medical service.

2. When multiple ICD-10 codes are applicable to one line item, the codes must be claimed on the same line. The correct submission of multiple three-character and / or extended ICD-10 codes is for the ICD-10 code to be followed by a **space then a forward slash then a space** then the next code.

   For example codes S16, T07 and T16 all apply to the same patient encounter (the underscore _ used in the following example represents a space):

Incorrect submission: S16/T07/T16
Correct submission: S16_/_T07_/_T16

[References –Circular 36 of 2005 and 19 of 2007, Council for Medical Schemes, Minutes of the Technical Sub-committee meeting held on 12 September 2007, ICD-10 National Task Team.]
[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

GSN0105 **Electronic Claims containing ICD-10 Codes**

1. The **delimiter for electronic claims** will be determined by the electronic standard used i.e. EDIFACT and XML might differ depending on the format used.

[References –Circular 36 of 2005 and 19 of 2007, Council for Medical Schemes, Minutes of the Technical Sub-committee meeting held on 12 September 2007, ICD-10 National Task Team.]
[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

Code of Ethics for Clinical Coders (South Africa)

Clinical Coders shall be dedicated to providing the highest standard of clinical coding and billing services to employers, clients and patients

Clinical coders shall perform their work with honesty, attentiveness, responsibility and not exploit professional relationships with employers, employees, clients and patients for personal gain

Refuse to participate in or conceal illegal or unethical processes or procedures

Participate in ongoing education to ensure that skills and knowledge meet the appropriate level of competence.

Observe policies and legal requirements regarding confidentiality of patient related clinical information.

Apply the South African Coding Standards and other official reporting requirements for the purpose of Clinical coding.

Clinical coders should only assign and report codes that are clearly and consistently supported by practitioner documentation in the health record

Ensure that clinical record content justifies selection of diagnosis, procedures and treatment, consulting clinicians as appropriate.

Participate in quality improvement activities to ensure that the quality of coding supports the use of data for research, planning, evaluation and reimbursement, in the spirit of mutual respect for colleagues.

Clinical coders must strive to maintain and enhance the dignity, status, competence and standards of coding for professional services.

References

Code of Ethics for Clinical Coders (Australia) - the NCCH (National Centre for Classification in Health)
Coders code of conduct – United Kingdom
Code of Ethical Standards - American Academy of Professional Coders

This Code of Ethics for Clinical Coders (South Africa) is applicable to any person doing clinical coding

General Standard National (**GSN**00)

GSN0001
GSN – **G**eneral **S**tandard **N**ational
GSN00 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

- 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**

This standard has been replaced by **GSN**0101 **Mandatory Inclusion of ICD-10 Codes on Claims**.

[Correction, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

GSN0004 **Submission of claims**

This standard has been replaced by **GSN**0102 **Submission of Claims**.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

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]

The word "optional" in the ICD-10 volumes has been replaced by the word "mandatory" in South African coding environment.

Example: refer to note below S06 in the tabular list (volume 1)
"The following subdivisions are provided for optional use in a supplementary character position, where it is not possible or not desired to use multiple coding"

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, 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]

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 or the category 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.

Guideline
Sequelae of external causes of morbidity and mortality (Y85 – Y89) must be coded in addition to any codes for Sequelae of injuries, of poisoning and of other consequences of external causes (T90 – T98).

[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]

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, ICD-10 National Task Team]

General Standards related to Claims (**GSN**01)

GSN0101
GSN – **G**eneral **S**tandard **N**ational
GSN01 Covers General Standards related to Claims
0101 – A unique number allocated to the standard (the Standard Number)

GSN0101 **Mandatory Inclusion of ICD-10 Codes on Claims**

1. The requirement for all health care providers, diagnosing and non-diagnosing, to **indicate the diagnosis(es) for each medical service rendered** on all claims submitted to a medical scheme or provided to a member for claim(s) submission to a medical scheme has been defined as per the *Regulations to the Medical Schemes Act* published in Government Gazette No. 20556 of October 1999.

2. Providing a diagnostic code on claims is not limited to health care providers in **private practice**, therefore rendering their own claims. Health care providers working within the **public health sector** are also required to provide ICD-10 diagnostic codes.

3. All ICD-10 diagnostic coding must be performed as per the **World Health Organisation's official rules and conventions**.

4. South Africa will continue to use the ICD-10 diagnostic code schema as the **National Standard** for the foreseeable future.

5. In any situation in which a definitive diagnosis is not made, a **sign and / or symptom code** would be appropriate for use.

6. In the instance where the first health care provider treating the patient and that of the second health care provider 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 health care provider**s, for a number of reasons.

7. **Matching the diagnosis and treatment** should not become prescriptive in nature. It will be up to each individual medical scheme to profile health care providers using treatment that differs from the norm.

[Reference – Final Document, ICD-10 implementation, August 2004 and Circular 28 of 2007, Council for Medical Schemes]

GSN0101 **Mandatory Inclusion of ICD-10 Codes on Claims** replaces **GSN**0003 **ICD-10 Codes on Claims** [Correction, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

GSN0102 **Submission of Claims**

1. **Claims submitted by Hospitals** must have the ICD-10 code(s) specified at the highest level i.e. header level or level 1. This means that ICD-10 codes do not have to be specified at line item level (detailed service items).

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

3. **Claims containing referring health care provider information and ICD-10 code(s)** (non-hospital) must indicate the referring provider's diagnostic codes but not at the line item level linked to procedural codes. Rather, the provider's details (name and surname, PCNS number, professional council number) and accompanying diagnoses must be presented at a higher summary level.

   To accommodate claims by multiple treating health care providers within a group, association or partnership practice, it is necessary to allow for **multiple referring provider** details as well as their respective ICD-10 codes. In such cases, the referring provider's details and ICD-10 codes would

need to be explicitly linked to the relevant treating service provider referred to within that claim and may require that the referring provider's information and diagnoses be specified in some place other than at the "header" of the claim. For instance, the claim may allow for summary sections containing treating service provider details, referring service provider details and ICD-10 codes applicable to a series of line items and whenever any of the diagnoses by the treating service provider, referring service provider or referring service provider change for a set of lines, a new summary section must be inserted into the claim.

Therefore, unless the claim explicitly denotes a set of ICD-10 codes as those supplied by a specific referring service provider linked to a specific treating service provider elsewhere in the claim (as described above), any "header level" ICD-10 codes which may be present will be assumed to be supplied by the referring service provider and will be applicable to all services rendered on the specific claim.

While the population of the referring service provider's information and diagnostic code(s) into the appropriate field is not mandatory, it must be noted that the **existence of this field is mandatory**. All parties are therefore requested to ensure that fields containing referral diagnoses data are not discarded in the transmission of data to or at the medical scheme or administrator.

4. When **Dental Technician Laboratories** submit their own claims for reimbursement, these practices need to use the same principle as the referring health care providers by supplying the dentist or dental specialist's details and diagnostic codes as referral information.

[Reference – Final Document, ICD-10 implementation, August 2004 and Circulars 19 and 28 of 2007, Council for Medical Schemes]

GSN0102 **Submission of Claims** replaces **GSN**0004 **Submission of claims**
[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

GSN0103 **Paper and Electronic Claims containing ICD-10 Codes**

1. Provision must be made for a maximum of ten (10) ICD-10 codes per line item.

2. The functionality of **capturing ICD-10 codes** is in the domain of the Practice Management Application (PMA) used by the service provider.

3. **Submission of three-character ICD-10 codes** excludes the dot / full stop. For example code T16:

   Incorrect submission: T16**.**
   Correct submission: T16

4. **Submission of extended character ICD-10 codes** includes the dot / full stop. For example code K35.9:

   Incorrect submission: K359
   Correct submission: K35.9

5. Using **ditto characters (")** to indicate repeated diagnoses codes is not allowed on any claim.

6. Submission of ICD-10 codes on **only the first line of a multi-line claims** does not meet with legislative requirements.

7. It is inappropriate for service providers and / or medical schemes / administrators to **assume or flood down ICD-10 codes** against claim lines that do not have the actual ICD-10 code(s) clearly indicated by the treating service provider.

8. ICD-10 code(s) must be claimed **without descriptions** in order to maintain a patient's privacy and confidentiality.

9. **No spaces are allowed within ICD-10 codes** (the underscore _ used in the following example represents a space).

   Incorrect submission: M79._20/I15._0/K35._9
   Correct submission: M79.20_/_I15.0_/_K35.9

10. **No hyphens are allowed within ICD-10 codes**.

    Incorrect submission: M79-20/I15-0/K35-9
    Correct submission: M79.20_/_I15.0_/_K35.9

11. **No brackets are allowed within ICD-10 codes**.

    Incorrect submission: (M79.20)(I15.0)(K35.9)
    Correct submission: M79.20_/_I15.0_/_K35.9

12. **No indication of primary or secondary diagnosis** is required. The sequence will infer the primary diagnosis.

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

[References –Circular 36 of 2005 and 19 of 2007, Council for Medical Schemes, Minutes of the Technical Sub-committee meeting held on 12 September 2007, ICD-10 National Task Team.]
[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

GSN0104 **Paper Claims containing ICD-10 Codes**

1. If an ICD-10 code cannot be accommodated on the same printed line on a claim, then it will be recognized as a roll-over or content wrap if it is on the **line directly below** the description of the rendered medical service.

2. When multiple ICD-10 codes are applicable to one line item, the codes must be claimed on the same line. The correct submission of multiple three-character and / or extended ICD-10 codes is for the ICD-10 code to be followed by a **space then a forward slash then a space** then the next code.

   For example codes S16, T07 and T16 all apply to the same patient encounter (the underscore _ used in the following example represents a space):

   Incorrect submission: S16/T07/T16
   Correct submission: S16_/_T07_/_T16

[References –Circular 36 of 2005 and 19 of 2007, Council for Medical Schemes, Minutes of the Technical Sub-committee meeting held on 12 September 2007, ICD-10 National Task Team.]
[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

GSN0105 **Electronic Claims containing ICD-10 Codes**

1. The **delimiter for electronic claims** will be determined by the electronic standard used i.e. EDIFACT and XML might differ depending on the format used.

[References –Circular 36 of 2005 and 19 of 2007, Council for Medical Schemes, Minutes of the Technical Sub-committee meeting held on 12 September 2007, ICD-10 National Task Team.]
[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, 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
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 and Volume 2, Second Edition, page 82 indicate 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**.**

Example:
Patient presents with tuberculosis of lung and Kaposi's sarcoma as a result of the HIV disease
PDX: B20.0 HIV disease resulting in mycobacterial infection
SDX: A15.3 Tuberculosis of lung, confirmed by unspecified means
SDX: 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 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 in 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]

DSN0103 **Coding of infections with drug resistant micro-organisms**

Assign a code for the infection in the primary position and additional codes for the causative organism and the drug resistant agent.

Example:
Patient admitted with a wound infection one week post cholecystectomy. Causative organism stated to be methicillin-resistant staphylococcus aureus (MRSA).
PDX: T81.4 Infection following a procedure, not elsewhere classified
SDX: B95.6 Staphylococcus aureus as the cause of diseases classified to other chapters
SDX: U80.1 Methicillin resistant agent
SDX: Y83.6 Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure: removal of other organ (partial) (total)

[Reference – Minutes of the Technical Subcommittee meeting held on 07 May 2008, ICD-10 National Task Team]

DSN0104 **Coding of other infections**

Guideline when coding mycobacterium other than tuberculosis (MOTT)
Assign an appropriate code from the A31._ category as specified in the Alphabetical Index (Volume 3)

[Reference – Minutes of the Technical Subcommittee meeting held on 07 May 2008, ICD-10 National Task Team]

DSN0105 **Coding diarrhoea and gastroenteritis without further specification**

Diarrhoea and gastroenteritis without further specification will be assumed to be of infectious origin and the condition will be classified to A09 Diarrhoea and gastroenteritis of presumed infectious origin.

[Reference – Minutes of the Technical Subcommittee meeting held on 07 May 2008, 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
M8010/3 Carcinoma NOS, 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 haematopoetic 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 haematopoetic 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 1:
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

Example 2:
Patient is admitted one day post chemotherapy with dehydration, nausea and vomiting.
PDX: E86 Volume depletion
SDX: R11 Nausea and vomiting
SDX: Y43.3 Adverse effects in therapeutic use: other antineoplastic drugs
SDX: C56 Malignant neoplasm of ovary
SDX: M9080/3 Teratoma, malignant, primary site, NOS

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.

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]
[Correction to example at C97 Malignant neoplasms of independent (primary) multiple sites, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, 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 haemophilliac
PDX: D66 Hereditary factor VIII deficiency
SDX: R04.0 Epistaxis

Guideline
Sometimes an additional code is required to fully describe a diagnosis with a manifestation. Certain symptoms that represent important problems in medical care in their own right should therefore be coded in addition to the underlying condition. Refer to point (f) below chapter XVIII in the tabular list (volume 1).

[Reference – Minutes of the Technical Subcommittee meeting held on 05 July 2006, ICD-10 National Task Team]
[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, 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/m^2
Obesity (grade 2) as BMI 30 – 39.9 kg/m^2
Morbid Obesity (grade 3) as BMI > 40kg/m^2

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
- 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

Coding impairment of heart muscle
Clinical coders should request more information when the description “impairment of heart muscle” is documented. “Impairment of heart muscle” should be coded to I51.5 if no further information is available.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, ICD-10 National Task Team]

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 1:
Patient admitted with COPD and Emphysema
PDX: J44.9 Chronic obstructive pulmonary disease, unspecified
SDX: J43.9 Emphysema, unspecified

Example 2:
Patient admitted with chronic bronchitis with emphysema
PDX: J44.8 Other specified chronic obstructive pulmonary disease

Rules on assignment
Take note of the inclusion and exclusion notes below J43 and J44 in the tabular list (volume 1). Emphysema with chronic bronchitis will be coded to J44.–

[Reference – Minutes of the Technical Subcommittee meeting held on 02 August 2006, ICD-10 National Task Team]
[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, 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]

DSN1007 **Community acquired pneumonia**

Community acquired pneumonia is pneumonia caused by organisms outside hospital i.e. it is not nosocomial or hospital acquired pneumonia.
Code to J18.9 Pneumonia, unspecified or assign an appropriate code for the pneumonia as documented by the doctor.

[Reference – Minutes of the Technical Subcommittee meeting held on 07 May 2008, ICD-10 National Task Team]

Diagnosis Standard National – 11

Diseases of the digestive system (K00 – K93)

Guideline when coding degenerative leiomyopathy

Clinical coders should request more information when the description “degenerative leiomyopathy” is documented. Degenerative leiomyopathy will be coded like a syndrome. Refer to **GSN**0013 **Coding of Syndromes**.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, 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 it's 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 (5^{th}) 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 osteoarthrosis. 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]

DSN1305 **Site of musculoskeletal involvement**

Code each site individually when multiple site involvement of the musculoskeletal system is documented. The 5^{th} character option of '0' is not to be assigned if multiple sites are listed by the Physician.

Example:
Juvenile rheumatoid arthritis of the shoulder, hand and ankle
PDX: M08.01: Juvenile rheumatoid arthritis, shoulder region
SDX: M08.04: Juvenile rheumatoid arthritis, hand
SDX: M08.07: Juvenile rheumatoid arthritis, ankle and foot

M08.00 Juvenile rheumatoid arthritis, multiple sites cannot be used in this situation

This code can only be assigned if the Physician does not list the individual sites, and states for e.g. Juvenile rheumatoid arthritis, multiple sites

If there is multiple involvement of a single joint, assign an appropriate code if an option is available for e.g. tear of meniscus [R] knee, involving anterior and posterior cruciate ligament.

If there is bilateral involvement, assign an appropriate code if an option is available.

Example:
Bilateral primary arthrosis of the knee
Correct code: M17.0: Primary gonarthrosis of knee

Refer to the excludes note under M15 Polyarthrosis
Excludes: bilateral involvement of a single joint (M16 – M19)

Multiple involvement of a single joint may lead to the patient having symptoms in multiple areas of the body, this however does not mean that 5th character option "0" "multiple sites" must be assigned or that the multiple sites of the body that are affected should be coded.

Example:
Ankylosing spondylitis of the thoracic region with pain radiating to the lower back, cervical region, and upper limbs

PDX: M45.X4 Ankylosing spondylitis, thoracic region

You can assign additional codes for the lower back pain, cervicalgia and pain in upper limbs if these represent important problems in the medical care rendered.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 04 February 2009, 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 – 15

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

DSN1501 **Pregnancy with abortive outcome**

Abortion
An abortion is generally defined as the delivery or loss of the products of conception up to and including the twentieth (20^{th}) week of gestation.

Refer to the Act No. 1 of 2008: Choice on Termination of Pregnancy Amendment Act, 2008.

003 Spontaneous abortion
Spontaneous abortions occur without any instrumentation. They may be threatened, inevitable, incomplete or complete.

O20.0 Threatened abortion
Threatened abortion is any bleeding or cramping of the uterus in the first twenty two weeks of pregnancy.

Inevitable abortion is an abortion that is bound to happen.

If part of the products of conception are retained the abortion is **incomplete**.

If all of the products of conception are passed and the uterus has contracted towards normal size and the cervix has closed, the abortion is **complete**.

Induced abortions are those done for medical or elective reasons. When an abortion is done for a medical reason, assign a code from the appropriate category in the primary position to indicate the reason for the abortion and an additional code from category O04 Medical abortion.

Example 1:
Patient admitted for an elective abortion at 12 weeks.
PDX: O04.9 Medical abortion, complete or unspecified, without complication

Example 2:
Patient admitted for a medical abortion at 22 weeks of gestation due to rhesus isoimmunisation
PDX: O36.0 Maternal care for rhesus isoimmunization
SDX: O04.9 Medical abortion, complete or unspecified, without complication

Should the outcome of the delivery be a live born infant, then the primary diagnosis code will remain the reason for the medical abortion. An additional code from category O04 Medical abortion will not be assigned.

Example:
Patient admitted for a medical abortion at 22 weeks of gestation for suspected damage to foetus following a medical procedure
PDX: O35.7 Maternal care for (suspected) damage to fetus by other medical procedures
SDX: Z37.0 Single live birth

O02.1 Missed abortion
Missed abortion occurs when the foetus dies and is retained in utero.

Septic abortion develops when the contents of the uterus become infected before, during or after an abortion.

Habitual abortion is the occurrence of three or more consecutive spontaneous abortions.

O05 Other abortion
Other abortion includes illegally induced abortion – the illegal interruption of pregnancy by any means.

O06 Unspecified abortion
Unspecified abortion indicates a direct inadvertent abortion i.e. where the patient undergoes uterine surgery (e.g. hysterectomy or dilatation and curettage) and the pregnancy is therefore terminated.

O07 Failed attempted abortion
Failed attempted abortion is the failure or attempted induction of abortion – legal or illegal. This means that the foetus has not been removed.

O00 Ectopic Pregnancy
Development of the embryo outside the uterine cavity, also called extra-uterine pregnancy.

Coding of Pregnancy with abortive outcome (O00 – O008)

Episode as described in categories O00 – O008
The period of admission for treatment until discharge

Complication following abortion and ectopic and molar pregnancy, current episode
This is when the complication occurs during the same episode of care following abortion and ectopic and molar pregnancy.

Complication of abortion, current episode (O00 – O002)
Use an additional code from category O08 Complication following abortion and ectopic and molar pregnancy to indicate any associated complications for categories O00 – O002.
An additional code is required for the classification of the specific complication if the O08._ code description is not specific.

Example:
Patient admitted with a rupture tubal pregnancy resulting in salpingitis
PDX: O00.1 Tubal pregnancy
SDX: O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy
SDX: N70.9 Salpingitis and oophoritis, unspecified

Complication of abortion, current episode (O03 – O06)
Assign the appropriate fourth character code for categories O03 – O06 for complications occurring during the same episode of care following abortion.
An additional code is required for the classification of the specific complication if the fourth character code description is not specific.
Use an additional code from category O08 Complication following abortion and ectopic and molar pregnancy to indicate any associated complications for categories O00 – O06 when they have a fourth character of .3 or .8.

Example 1:
Patient admitted for a complete medical abortion resulting in pelvic peritonitis
PDX: O04.5 Medical abortion, complete or unspecified, complicated by genital tract and pelvic infection
SDX: N73.5 Female pelvic peritonitis, unspecified

Therefore O08 Complications following abortion and ectopic and molar pregnancy should not to be used as additional codes for O03 – O07 except when they have a fourth character of .3 or .8.

Example 2:
Patient admitted for a complete medical abortion. Developed post-operative shock.
PDX: O04.5 Medical abortion, complete or unspecified, complicated by genital tract and pelvic infection
SDX: O08.3 Shock following abortion and ectopic and molar pregnancy

O07 Failed attempted abortion
Assign the appropriate fourth character code for category O07 for complications occurring during the same episode of care following abortion.
An additional code is required for the classification of the specific complication if the fourth character code description is not specific.
Use an additional code from category O08 Complication following abortion and ectopic and molar pregnancy to indicate any associated complications for category O07 when there is a fourth character of .3 or .8.

Subsequent Episode
Period after discharge or previous treatment

Complication following abortion and ectopic and molar pregnancy, subsequent episode
The O08 Complication following abortion and ectopic and molar pregnancy category of codes should be used in the **primary position** when the complication of pregnancy with abortive outcome occurs as a subsequent episode i.e. when the patient has been discharged or treated previously following an abortive outcome of pregnancy and is re-admitted with complications.

The exception to this rule is when the patient is admitted with retained products of conception which will be coded to the O03 – O06 category with the appropriate fourth character code of .0 – .4. In this instance it is not a complication of the abortion.
(Incomplete abortion includes retained products of conception following abortion)

Example 1:
Patient admitted for Oophoritis following a spontaneous abortion.
PDX: O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy
SDX: N70.9 Salpingitis and oophoritis, unspecified

Example 2:
Patient had a therapeutic abortion and subsequently admitted with retained products of conception.
PDX: O04.4 Medical abortion, incomplete, without complication

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

DSN1502 **Pregnancy**

Primigravida

An elderly primigravida is generally related to a primigravida who is 35 years and older.

A young primigravida is generally related to a primigravida who is 18 years and younger.

Coding Pre-existing hypertension complicating pregnancy, childbirth and the puerperium

Guideline
An additional code may be assigned in order to describe the patient's condition.

Example:
Patient has pre-existing hypertensive renal disease with renal failure.
PDX: O10.2 Pre-existing hypertensive renal disease complicating pregnancy, childbirth and the puerperium
SDX: I12.0 Hypertensive renal disease with renal failure

HELLP syndrome (O14.1)
A syndrome featuring a combination of "H" for haemolysis "EL" for elevated liver enzymes and "LP" for low platelet count. The HELLP syndrome is a recognised complication of pre-eclampsia and eclampsia (toxaemia) of pregnancy.

Coding of HELLP syndrome which resulted in a ruptured liver
Sequence O14.1 Severe pre-eclampsia as the primary diagnosis with an additional code O26.6 Liver disorders in pregnancy, childbirth and the puerperium as there is no specific code for non-traumatic rupture of the liver.
[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, ICD-10 National Task Team]

Early Pregnancy
Early pregnancy is considered to be before twenty-two (22) completed weeks of gestation therefore < twenty-two (22) weeks pregnant.

Late pregnancy
Late pregnancy is considered to be after twenty-two (22) completed weeks of gestation therefore = and > twenty-two (22) weeks pregnant.

Haemorrhage in early pregnancy
Haemorrhage in early pregnancy will be coded to O20._ Haemorrhage in early pregnancy.

Pregnancy
– complicated by
– – haemorrhage
– – – before 22 completed weeks of pregnancy

Antepartum haemorrhage
Antepartum haemorrhage will therefore be considered to be bleeding occurring after 22 completed weeks of gestation and should be coded to category O46 Antepartum haemorrhage, not elsewhere classified.

Vomiting in early pregnancy
Vomiting in early pregnancy will be coded to O21.0 Mild hyperemesis gravidarum and to O21.1 Hyperemesis gravidarum with metabolic disturbance if further complicated by metabolic disturbance.

Vomiting in late pregnancy
Vomiting in late pregnancy will be coded to O21.2 Late vomiting of pregnancy.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

DSN1503 **Labour and Delivery**

Antenatal
Prenatal, existing or occurring before birth.

Antepartum
Occurring before parturition or childbirth.

Multiple gestation (O30)
This category should be assigned as the primary diagnosis when no other condition classifiable to Chapter XV is present. This category should be as an additional code when assigning other codes from chapter XV.

Example:
Elective caesarean section for twin pregnancy. Both liveborn.
PDX: O30.0 Twin pregnancy
SDX: O84.2 Multiple delivery, all by caesarean section
SDX: Z37.2 Twins, both liveborn

Maternal care for known or suspected malpresentation, disproportion and abnormality of pelvic organs (O32 – O34)

When a malpresentation of foetus, disproportion or abnormality of maternal pelvic organs is present before the onset of labour and a procedure e.g. a caesarean section is carried out, assign a primary diagnosis code from categories O32 Maternal care for known or suspected malpresentation of fetus or O33 Maternal care for known or suspected disproportion or O34 Maternal care for known or suspected abnormality of pelvic organs

Example:
Patient admitted for breech presentation. Elective caesarean section carried out. Delivered a healthy live born infant.
PDX: O32.1 Maternal care for breech presentation
SDX: O82.0 Delivery by elective caesarean section
SDX: Z37.0 Single live birth

When a malpresentation of foetus, disproportion or abnormality of maternal pelvic organs is diagnosed during labour and requires medical care, assign a primary diagnosis code from categories O64 Obstructed labour due to malposition and malpresentation of fetus or O65 Obstructed labour due to maternal pelvic abnormality or O66 Other obstructed labour

Example:
Obstructed labour due to cephalopelvic disproportion. Emergency caesarean section. Delivered a healthy liveborn infant.
PDX: O65.4 Obstructed labour due to fetopelvic disproportion
SDX: O82.1 Delivery by emergency caesarean section
SDX: Z37.0 Single live birth

Maternal care for known or suspected foetal problems
Guideline
Poor / lack of foetal movement should be coded to O36.8 Maternal care for other specified fetal problems.

False Labour
Intermittent non-productive muscular contractions of the womb (uterus) during pregnancy, most commonly in the last two months before full term. These contractions are non-productive in the sense that they do not produce any flattening (effacement) or dilation (opening up) of the cervix.

Premature / Preterm Labour
Labour occurring between the twentieth and the thirty-seventh completed weeks of pregnancy.

O60.0 Preterm labour without delivery
Labour occurring before 37 completed weeks of pregnancy, without delivery

O60.1 Preterm labour with preterm delivery
Labour occurring before 37 completed weeks of pregnancy with a delivery

O60.2 Preterm labour with term delivery
Labour occurring before 37 completed weeks with delivery after 37 completed weeks of pregnancy

Example:
Patient was admitted into hospital at 30 weeks of gestation due to premature labour. Labour was delayed by pitocin therapy for two days. On day three, fetal distress was noted and an emergency caesarean section was performed and a live born infant was delivered.
PDX: O68.9 Labour and delivery complicated by fetal stress, unspecified
SDX: O60.1 Preterm labour with preterm delivery
SDX: O82.1 Delivery by emergency caesarean section
SDX: Z37.0 Single live birth
Needs to be finalized with the explanation of the O60.- codes

Labour may be divided into four stages:
The first stage (cervical dilation) begins with the onset of regular uterine contractions and ends when the os is completely dilated.
The second stage extends from the end of the first stage until the expulsion of the infant is completed.
The third stage extends from the expulsion of the child until the placenta and membranes are expelled.
The fourth stage denotes the hour or two after delivery when the uterine tone is established.

Prolonged Labour
Labour prololonged beyond the ordinary 18-hour limit.

1st stage of labour
Poor prognosis in the latent phase of labour
- Latent phase is prolonged when it exceeds 8hrs

Poor prognosis in the active phase of labour
- Labour is prolonged if the cervix dilates at a rate of less than 1 cm/hr.

2nd stage of labour
Poor prognosis
- Foetal head has not descended onto the pelvic floor after 2 hrs of full dilatation.
- If delivery has not occurred after 45 minutes of pushing in a nullipara or 30 minutes of pushing in a multipara.

Delivery (O80 – O84)

Single spontaneous delivery (O80)
This category of codes can only be used for a normal delivery when no abnormality or complication related to the delivery is classifiable elsewhere in chapter XV or when no instrumentation or manipulation is used during the delivery.

Example:
Patient delivered a healthy infant following a spontaneous vertex delivery.
PDX: O80.0 Spontaneous vertex delivery
SDX: Z37.0 Single live birth

Z37 Outcome of Delivery
A code from category Z37 must be assigned on the mother's record to indicate the outcome of the delivery.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

DSN1504 **Puerperium**

Postpartum
After childbirth or after delivery.

Puerperium
The period from the end of the third stage of labour until involution of the uterus is complete, usually lasting three to six weeks.

Puerperial Sepsis
An infectious, sometimes fatal, type of septicaemia with fever, associated with childbirth. The focus of infection is the uterus and etiologic agent is frequently a streptococcus.

Post Partum Haemorrhage

Primary post partum haemorrhage is blood loss > 500mls in the first 24 hours after delivery or as a visibly excessive blood loss after delivery.

Secondary post partum haemorrhage is a passage of fresh blood or clots more than 24 hours after delivery.

Admission for post partum care
Assign Z39.0 as the primary diagnosis when a patient is admitted after delivery in the ambulance or transferred from the hospital where she delivered to another hospital for post partum care and there are no complications.

Example:
Patient admitted into hospital following a spontaneous delivery of a live born infant in the ambulance.
PDX: Z39.0 Care and examination immediately after delivery

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

Guideline when submitting a claim for a breast pump

Code Z39.1 Care and examination of lactating mother should be used when a post natal nursing sister, midwife or lactation consultant supplies or provides a patient with a breast pumps.

Code Z76.8 Persons encountering health services in other specified circumstances should be used by pharmacies or other supplies that sell and rent breast pump.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, 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 sign and symptom codes e.g. R-codes

'Sign and symptom' codes that begin with the letter 'R' are used if no definite diagnosis has been established at the end of an episode of health care or if a patient is treated symptomatically at a primary health care level. The information that permits the greatest degree of specificity and knowledge about the condition that necessitated care or investigation should be recorded. This should be done by stating a symptom, abnormal finding or problem, rather than qualifying a diagnosis as "possible", "questionable" or "suspected", when it has been considered but not established.

Example 1:
Patient presenting with photophobia, fever and neck stiffness. Diagnosis – Meningitis
Code the definitive diagnosis – Meningitis
PDX: G03.9 Meningitis, unspecified

Example 2:
Patient admitted with sickle-cell crisis and acute chest syndrome.
PDX: D57.0 Sickle-cell anaemia with crisis
Acute chest syndrome is an integral part of sickle cell crisis and therefore not coded separately.

You do not have to code the symptoms. Therefore signs and / or symptoms inherent to a diagnosis should not be assigned in addition to the code assigned for the specified diagnosis unless these represent important problems in medical care in their own right.

- "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.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]
[Amendment, Reference – Minutes of the Technical Subcommittee meeting held on 05 February 2009, ICD-10 National Task Team]

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 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

- Assign a code for each drug if multiple drugs documented.
- Assign a code for each active ingredient of a combination drug sequencing the one with the highest strength in the absence of detailed information.
- Code the 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 1:
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

Example 2:
Child admitted for poisoning. Accidentally ingested myprodol which was left on the kitchen table at home. Myprodol [active ingredients: Ibuprofen 200mg, Paracetamol 250mg and Codeine Phosphate 10mg].

PDX: T39.1 Poisoning: 4-aminophenol derivatives
SDX: T39.3 Poisoning: other nonsteroidal anti-inflammatory drugs [NSAID]
SDX: X40.09 Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, home, during unspecified activity
SDX: T40.2 Poisoning: other opioids
SDX: X42.09 Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, home, during unspecified activity

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

[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]

Coding Guideline when coding an allergy to food (any) (ingested) with gastroenteritis
PDX: T78.1 Other adverse food reactions, not elsewhere classified
SDX: K52.2 Allergic and dietetic gastroenteritis and colitis
SDX: X49._ Accidental poisoning by and exposure to other and unspecified chemicals and noxious substances (with the appropriate fourth and fifth character codes)

Coding Guideline when coding food poisoning
PDX: T62.9 Toxic effect: noxious substance eaten as food, unspecified
SDX: X49._ (if accidental) or X69._ (if intentional) or Y19._ (if undetermined intent) with the appropriate fourth and fifth character codes

[Reference – Minutes of the Technical Subcommittee meeting held on 07 May 2008, 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]

DSN1904 **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]

DSN1905 **Coding Injuries**

Guidelines when coding injuries
1. The S-section is used for coding different types of injuries related to single body regions and the T-section covers injuries to multiple or unspecified body regions, as well as poisoning and other consequences of external causes.

2. Where multiple sites of injury are specified in the titles, the word “with” indicates involvement of both sites and the word “and” indicates involvement of either or both sites

4. When coding from chapter XIX, always use an external cause code in addition to codes from chapter XIX

Example:
Fracture of vault of skull with concussion without open intracranial wound. This occurred when the patient who was the driver of his car, collided with another car in a traffic accident, while going on holiday
PDX: S06.00: Concussion without open intracranial wound
SDX: S02.00: Fracture of vault of skull, closed
SDX: V43.51: Car occupant injured in collision with car, pick-up truck or van, driver, traffic accident, while engaged in leisure activity

5. The word “optional” in the ICD-10 volumes has been replaced by the word “mandatory” in South African coding environment.

Example:
Refer to note below S06 in the tabular list (volume 1)
“The following subdivisions are provided for optional use in a supplementary character position, where it is not possible or not desired to use multiple coding”

6. A fracture not indicated as closed or open should be classified as closed

Example:
A fracture of the mandible
PDX: S02.60: Fracture of mandible, closed

7. An intra-cavity injury not stated as open or closed, should be classified as closed

Example:
Traumatic pneumothorax
PDX: S27.00 Traumatic pneumothorax, without open wound into thoracic cavity

Sequencing rules when coding injuries
1. Code the internal injury as the main condition for internal injuries recorded with superficial injuries and / or open wounds.

Example:
Patient sustained an injury to the lung. Stab wound to back wall of chest.
PDX: S27.31 Other injuries of lung, with open wound into thoracic cavity
SDX: S21.2 Open wound of back wall of thorax
SDX: X99.99 Assault by sharp object, unspecified place, during unspecified activity

2. Code the intracranial injury as the main condition for fractures of skull and facial bones with associated intracranial injury.

Example:
Closed fracture of vault of skull with concussion without open intracranial wound
PDX: S06.00 Concussion, without open intracranial wound
SDX: S02.00 Fracture of vault of skull, closed

3. Code intracranial haemorrhage as the main condition for intracranial haemorrhage recorded with other injuries to the head.

Example:
Patient admitted with a fracture of the skull with a subdural haemorrhage following a fall from the balcony of his apartment.
PDX: S06.50 Traumatic subdural haemorrhage, without open intracranial wound
SDX: S02.90 Fracture of skull and facial bones, part unspecified, closed
SDX: W13.09 Fall from, out of or through building or structure, home, during unspecified activity

4. Code the fracture as the main condition for fractures recorded with open wounds of the same location.

Example:
Fracture shaft of humerus with an open wound of the same site.
S42.31 Fracture of shaft of humerus, open

[Reference Volume 2, First Edition, page 123 or Second Edition, page 129]

Multiple Injury coding rule
When multiple injuries are recorded, code all the individual injuries sequencing the most life threatening condition in the primary position or as described in the South African definition of the primary diagnosis.

For multiple injuries of the same anatomic site, organ or body region, list each injury individually.

Example 1:
Patient sustained multiple fractures to the lower leg. Open fracture of lower end of tibia and fibula. Closed fracture of the lateral malleolus. This occurred when the patient fell out of a tree, at home, while gardening
PDX: S82.31: Fracture of lower end of tibia, open (this includes fracture of fibula)
SDX: S82.60: Fracture of lateral malleolus, closed
SDX: W14.03: Fall from tree, home, while engaged in other types of work (ECC)

Guideline
ICD-10 does not make provision for bilateral fractures, e.g. closed bilateral fracture of shaft of humerus. Assign the code for the fracture once if the fractures are the same.
This rule will not apply to providers who are required to provide codes at a line level.

If the fractures differ and one fracture is open and the other is closed. Assign individual codes for each fracture and sequence appropriately.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

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).

Exception:
This will not apply when the injury does not heal in cases of osteomyelitis, malunion and nonunion etc. In this instance, assign the appropriate code from the musculoskeletal section with the appropriate 4th and 5th character codes.

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]

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, 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]

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/later 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]

DSN2002 **Coding for Compensation for Occupational Injuries and Diseases (COIDA)**

In terms of the Compensation for Occupational Injuries and Diseases Act no.130 of 1993 (COIDA) an employee would not be covered by this legislation if involved in an accident on his way to work or traveling home from work.

This exception to this is found in section 22(5) of (COIDA) which states that an employee would be covered under the following circumstances:

- Employee is transported free of charge to and from work;
- Vehicle driven by employer or employee;
- Vehicle specially provided for this purpose.
- This would for example be a "staff bus."

External Cause Codes (ECC) – 5th Character – Activity

0 – While engaged in sports activity
This excludes sports activities which include - paid work (manual) (professional), work for salary, bonus and other types of income.

1 – While engaged in leisure activities
Excludes: sports activities (0)

2 – While working for income
Paid work (manual) (professional)
Transportation (time) to and from such activities i.e. (work activities) e.g. a medical representative traveling from work to a client or a health practitioner traveling from a patient back to his/her practice or hospital etc.

Work for salary, bonus and other types of income

3 – While engaged in other types of work
NB – Duties for which one would not normally gain an income

4 – While resting, sleeping, eating or engaging in other vital activities

8 – While engaged in other specified activities

9 – During unspecified activity

The use of the 5th Character in the ECC

2 – While working for income (meaning as an employee).
Paid work (manual) (professional) (This includes professional sports)
Transportation (time) to and from such activities i.e. (work activities)
Work for salary, bonus and other types of income

In terms of COIDA it would be therefore be more correct to say whilst working as an employee.

Footnote:

1. The definition of an employee in terms of COIDA reads as follow "employee means a person who has entered into or works under a contract of service of apprenticeship or learnership, with an employer, whether the contract is express or implied, oral or in writing and whether **remuneration** is calculated by time or by work done, **or is in cash or kind.**"
2. The Commissioner does not regard an injury to a professional sport person as an injury in terms of COIDA. The reason being that the employer does not have control over such a person.
3. In terms of the Compensation for Occupational Injuries and Diseases Act no.130 of 1993 (COIDA) an employee would not be covered by this legislation if involved in an accident on his way to work or traveling home from work. This exception to this is found in section 22(5) of (COIDA) which states that an employee would be covered under the following circumstances:
    - Employee is transported free of charge to and from work;
    - Vehicle driven by employer or employee ;
    - Vehicle specially provided for this purpose.
4. The person traveling from home to a client will be considered in terms of COIDA if his job description states that he has to see clients.

COIDA Definitions

- DOMESTIC EMPLOYER
  In terms of the definition of an employee, domestic employees are excluded from COIDA. This would mean that if a domestic employee can show that he was injured through the negligence of his employer he would be able to sue his employer. This liability is normally covered in a person's Household Insurance Policy under "Public Liability". Cases of domestic employees suing their employers have been reported in the past. The Commissioner indicated about two years ago that his intention is to include these employees under COIDA, however this has not materialised yet.

- CONTRACTUAL WORKER
  An employer has to declare at the end of every year what salary was paid to full time employees and contracted employees. These employees would therefore be covered by COIDA.

- SELF EMPLOYED
  An employer can only register in terms of COIDA when he employs one or more persons. A self employed person is therefore not covered by COIDA.

- PROFESSIONAL SPORTS
  As indicated previously persons participating in professional sports are not covered.

- EMPLOYEE
  "employee means a person who has entered into or works under a contract of service of apprenticeship or learnership, with an employer, whether the contract is express or implied, oral or in writing and whether **remuneration** is calculated by time or by work done, **or is in cash or kind**."

Footnote:
All the above will be identified by the 5th character 2.
Special attention must be given as to when payment will be made by various payers such as COIDA, Insurances etc.

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 06 August 2008, ICD-10 National Task Team]

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]

DSN2131 **Coding of Rehabilitation**

When a patient is admitted for rehabilitation, the primary diagnosis code should be the condition resulting in the patient requiring rehabilitation. The rehabilitation code should be coded as an additional code.

Example:
Patient admitted for rehabilitation of a stroke. Patient presents with hemiplegia and dysphagia.
PDX: I64 Stroke, not specified as haemorrhage or infarction
SDX: G81.9 Hemiplegia, unspecified
SDX: R13 Dysphagia
SDX: Z50._ Care involving use of rehabilitation procedures

[Reference – Minutes of the Technical Subcommittee meeting held on 07 May 2008, ICD-10 National Task Team]

DSN2132 **Coding for Dental Laboratories**

The Dental Technician's Act has changed allowing them the option to submit claims directly to Healthcare Funders. Dental Technicians who choose to submit claims directly to Healthcare Funders are required to conform to the line item requirement i.e. the submission of ICD-10 codes at a line level is mandatory.

The appropriate codes for Dental Technicians to use are **Z46.3 Fitting and adjustment of dental prosthetic device** and **Z46.4 Fitting and adjustment of orthodontic device.**

Note: Refer to DSN2109 Re-cementation of a Crown / Bridge and DSN2110 Repair of a Denture

[Reference – Minutes of the Technical Subcommittee meeting held on 07 May 2008, ICD-10 National Task Team]

DSN2133 **Coding results of HIV tests**

Code positive serology (Elisa or Western Blot) for HIV-1 antibody to **R75 Laboratory evidence of human immunodeficiency virus [HIV]**
Code negative serology to **Z01.7 Laboratory examination**
Code positive PCR qualitative tests for HIV-1 Ag to **R75 Laboratory evidence of human immunodeficiency virus [HIV]**
Code negative PCR qualitative tests for HIV-1 Ag to **Z01.7 Laboratory examination**
Code PCR HIV VIRAL Load to **Z01.7 Laboratory examination**
Code PCR HIV Drug Resistance genotyping to **Z01.7 Laboratory examination**

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

Diagnosis Standard National – 22

Codes for special purposes (U00 – U99)

DSN2201 **Drug resistant tuberculosis**

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 kanamicin and/or amikacin
U50.50 Extensively drug resistant tuberculosis, primary resistance to INH and rifampicin, and any fluoroquinolone plus capreomycin and/or kanamicin and/or amikacin
U50.51 Extensively drug resistant tuberculosis, secondary resistance to isoniazid and rifampicin, and any fluoroquinolone plus one of: capreomycin and/or kanamicin 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]

Footnote:
The 5th character indicates whether drug resistance is primary or secondary as follows:
0 indicates Primary resistance (transmission of a resistant strain, not previously diagnosed or treated)

1 indicates Secondary resistance (previously diagnosed and treated, partially treated)

Reference: Document compiled by Nelson Nagoor, Igolide Health Networks, published on the PHISC website http://www.dhsolutions.co.za/phisc/

[Addition, Reference – Minutes of the Technical Subcommittee meeting held on 05 November 2008, ICD-10 National Task Team]

DSN2202 **Non-disclosure**

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]

DSN2203 **Bacterial agents resistant to antibiotics (U80 – U89)**

These categories should never be used in primary coding. They are provided for use as supplementary or additional codes when it is desired to identify the antibiotic to which a bacterial agent is resistant, in bacterial infection classified elsewhere

U80 Agent resistant to penicillin and related antibiotics
U80.0 Penicillin resistant agent
U80.1 Methicillin resistant agent
U80.8 Agent resistant to other penicillin-related antibiotic

U81 Agent resistant to vancomycin and related antibiotics
U81.0 Vancomycin resistant agent
U81.8 Agent resistant to other vancomycin-related antibiotic

U88 Agent resistant to multiple antibiotics
This category is provided for use when a bacterial agent is resistant to two or more antibiotics but there is insufficient detail to determine which antibiotic is contributing most to the “main condition”.

Guideline
The note indicates that “it should also be used for primary tabulation purposes when it is more convenient to record a single code; otherwise each specific antibiotic-resistant agent should be coded separately”.
In the South African environment each specific antibiotic-resistant agent should be coded separately.

U89 Agent resistant to other and unspecified antibiotics
U89.8 Agent resistant to other single specified antibiotic
U89.9 Agent resistant to unspecified antibiotic

[Reference – Minutes of the Technical Subcommittee meeting held on 07 May 2008, ICD-10 National Task Team]

Coding Definitions

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

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ICD-10 National Task Team
Extracts from minutes of the Technical, Operational and Training Task Team meetings

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