health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Changes to the SA ICD-10 Morbidity Coding Standard Version 6 June 2014

Developed to assist the Clinical Coder in the South African environment

Date: June 2014

A three month period will be allowed for the implementation of any operational changes and a six month period for any system related changes from the date of publication

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Acknowledgement

The National Department of Health would like to thank the Council for Medical Schemes (CMS) for stewardship of the ICD-10 Implementation Task Team from 2004 until January 2011.

Introduction

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~~ **was** a joint task team between the National Department of Health and the Council for Medical Schemes. **In 2011, the Task Team was formalized by the Director General of Health and in 2012, the Task Team was appointed as a Ministerial Task Team and functions under the auspices of the National Department of Health.** 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[1].

Date Implemented – 1996

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

The South African Code of Ethics has been replaced by the following:

South African Code of Ethics for Clinical Coders

Application of this Code

This Code applies to all persons doing clinical coding, irrespective of their background, experience, training or sector of work.

Coder's Ethical Principles

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

2) Clinical coders shall perform their work with honesty, attentiveness, responsibility and not exploit professional or other relationships with employers, employees, clients and patients for personal or undue commercial gain.

3) Clinical coders shall refuse to participate in or conceal any illegal, unlawful or unethical processes or procedures relating to coding or any aspect thereof.

4) Clinical coders shall participate in ongoing education to ensure that skills and knowledge meet the appropriate level of competence.

5) Clinical coders shall observe policies and legal requirements regarding patient consent, confidentiality and processing of patient-related clinical information and all personal information.

6) Clinical coders shall apply the South Africa Coding Standards and other official reporting requirements for the purposes of Clinical Coding, within what is lawful and ethical.

7) Clinical Coders should only assign and report codes that are clearly and consistently supported by practitioner documentation in the healthcare record.

8) Clinical coders shall ensure that clinical record content justifies selection of diagnosis, procedures and treatment, consulting clinicians as appropriate.

9) Clinical coders shall 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.

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

11) Clinical coders shall resolve conflicts and interpretational issues in a manner that is transparent, professional and constructive, and seek guidance from professional bodies when in doubt.

12) Clinical coders shall raise matters of unprofessional coding, or coding in contravention of this code with the appropriate authorities, and not victimize any coder who exercises this right.

References:

Code of Ethics for Clinical Coders (Australia), the National Centre for Classification in Health (NCCH)
Coders Code of Conduct, United Kingdom (UK)
Code of Ethical Standards, American Academy of Professional Coders (AAPC)

General Morbidity Coding Standards and Guidelines

GSN0002 Secondary Diagnosis/es

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~~B98)
    - 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

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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 biennial~~ly~~ update, should the situation warrant it.

GSN0013 Coding of Syndromes

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~~ **Type 2** diabetes mellitus without complications

GSN0014 **Updating of the SA ICD-10 Morbidity Coding Standards and Guidelines Document**

The South African ICD-10 **Morbidity** Coding Standards **and Guidelines** document will be updated as agreed on by the National Task Team following the agreed process. Any requests for updates, corrections and amendments can be submitted to the National Task Team for discussion

The SA ICD-10 **Morbidity** Coding Standards **and Guidelines** document will be updated annually unless an urgent change is required. A process for updating the coding standards has been compiled and included in the SA ICD-10 **Morbidity** Coding Standards **and Guidelines** document. Please refer to Appendix A.

A summary of changes will be compiled and included in the **SA ICD-10 Morbidity C**oding standards and **Guidelines** document after each update.

A three month period will be allowed for the implementation of any operational changes and a six month period for any system related changes.

A standard which is no longer valid will be removed. The standard number will not be re-used.

The latest version of the SA ICD-10 **Morbidity** Coding Standards **and Guidelines** document available on the ~~Council for Medical Schemes~~ National Department of Health's website (www.health.gov.za) must be referenced and used together with the ICD-10 volumes or the latest ICD-10 **Master Industry Table** (MIT) when coding and / or facilitating a coding course in the medical and or health insurance environment of SA.

GSN0016 **Dagger and asterisk system / convention**[2]

~~**The following extract comes from the ICD-10 Implementation Review January 2004 – October 2006 National Task Team On ICD-10 Implementation - October 2006**~~

~~**3.14.7.**~~ **Dagger codes not flagged to asterisk codes on the ~~BHF/DXS~~ ICD-10 Master Industry Table (MIT)**

Not all possible dagger codes are flagged to asterisk codes or with their asterisk combinations in the ~~BHF/DXS~~ ICD-10 Master Industry Table **(MIT)**~~, as~~ T~~t~~hese **combinations must** ~~need to~~ be applied if ~~as is~~ deemed clinically appropriate for individual cases. Thus knowledge of the conventions of the volumes of ICD-10, as well as clinical knowledge is critical in appropriate allocation of dagger and asterisk combinations.

In the ~~BHF/DXS~~ ICD-10 Master Industry Table **(MIT)**, only codes as per the ICD-10 volume 1 were flagged as dagger codes, however, it does not necessarily mean that a non-flagged code cannot be used as a dagger code as per coding rules.

[2] Refer to 3.1.3, the "dagger and asterisk system" in the WHO, ICD-10 Instruction Manual (Volume 2)

General Standards related to Claims

GSN0103 Paper and Electronic Claims containing ICD-10 Codes

4. Submission of extended character ICD-10 codes includes the dot / full stop. For example code K35.98:

Incorrect submission: K3598
Correct submission: K35.98

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._98
Correct submission: M79.20_/_I15.0_/_K35.98

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

Incorrect submission: M79-20/I15-0/K35-98
Correct submission: M79.20_/_I15.0_/_K35.98

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

Incorrect submission: (M79.20)(I15.0)(K35.98)
Correct submission: M79.20_/_I15.0_/_K35.98

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, ~~**C**~~childbirth and the ~~**P**~~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)

DSN01 Certain infectious and parasitic diseases (A00 – B99)

DSN0101 HIV / AIDS

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~~.

- Antibody test for HIV is positive (i.e. Elisa test or Western Blot test) and,
- Presence of AIDS defining medical diseases e.g. disseminated tuberculosis (TB), cryptococcal meningitis, Kaposi~~'s~~ sarcoma etc.(WHO stage 4)
- 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.

B20.6 HIV disease resulting in *Pneumocystis* ~~carinii~~ *jirovecii* pneumonia

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

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, **malignant**, primary site **(C46.–)**

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[3]

Please note that **the Instruction Manual** ~~(WHO, ICD-10, Volume 2), ICD-10, First Edition, page 113 and Volume 2, Second Edition, page 82~~ indicate**s** that B22.7 should be assigned ~~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**.**

[3] Refer to 4.4.4 Chapter specific notes in the WHO, ICD-10 Instruction Manual (Volume 2)

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, **malignant**, primary site **(C46.–)**

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 1:
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~~ U82.1 Resistance to methicillin
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)

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

Based on the WHO corrigenda, we can remove / add the following:
~~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.~~

If the medical record indicates that the patient had both gastroenteritis and vomiting then ~~A09 Diarrhoea and gastroenteritis without further specification will~~ A09.9 Gastroenteritis and colitis of unspecified origin should be assigned.

- *Gastroenteritis typically involves both diarrhea and vomiting*

If the medical record indicates that the patient had both diarrhea and vomiting, then ~~A09 Diarrhoea and gastroenteritis without further specification~~ A09.9 Gastroenteritis and colitis of unspecified origin and R11 Nausea and vomiting ~~will~~ should be assigned. The reason for this is to keep the record of the vomiting until the cause of the diarrhea has been established. ~~as the diarrhoea without further specification will be not be assumed to be of infectious origin.~~

DSN02 Neoplasms (C00 – D48)

DSN0201 Neoplasm Coding

Summary of Morphology Code and Description changes

Morphology Code	Morphology Code Description changed from	Morphology Code Description changed to / added
M8000/3	Neoplasm, malignant	Neoplasm, malignant, primary site
M8000/6	Neoplasm, metastatic	Neoplasm, malignant, metastatic site
M8010/3	Carcinoma NOS, primary site	Carcinoma**,** NOS, malignant, primary site
M8010/6	Carcinoma, metastatic, NOS	Carcinoma, NOS, malignant, metastatic site
M8090/3	Basal cell carcinoma NOS, primary site	Basal cell carcinoma**,** NOS, malignant, primary site (C44.–)
M8890/0	Leiomyoma NOS	Leiomyoma, NOS, benign
M8936/0		Gastrointestinal stromal tumour, benign
M8936/1		Gastrointestinal stromal tumour, NOS, uncertain whether benign or malignant
M8936/3		Gastrointestinal stromal sarcoma, malignant, primary site
M8936/6		Gastrointestinal stromal sarcoma, malignant, metastatic site
M9080/3	Teratoma, malignant, primary site, NOS	Teratoma, NOS, malignant, primary site
M9140/3	Kaposi~~'s~~ sarcoma, primary site	Kaposi sarcoma, malignant, primary site (C46.–)

Cancer[4]
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.

Guideline
The abbreviation "Ca" will be deemed to mean "cancer" and the morphology code **M8000/3 Neoplasm, malignant, primary site** will be assigned unless preceded by a morphological description.

Example 1:
Ca Breast
PDX: C50.9 Malignant neoplasm, breast, unspecified
SDX: M8000/3 Neoplasm, malignant, primary site

Example 2:
Basal Cell Ca skin on shoulder
PDX: C44.6 Malignant neoplasm, skin of upper limb, including shoulder

[4] Refer to the note below Cancer in the WHO, ICD-10 Alphabetical Index (Volume 3)

SDX: M8090/3 Basal cell carcinoma**,** NOS, **malignant,** primary site **(C44.–)**

~~Reference: See note below Cancer in the Alphabetical Index (Volume 3)~~

Morphology codes

- The use of morphology codes is currently not mandatory
  At the February 2014 ICD-10 National Task Team meeting, the mandatory use of morphology codes was postponed until further investigations are concluded on the most effective strategy for implementation.
- Coders are encouraged to make use of these codes
- The behaviour of the neoplasm can be changed to suit the diagnosis

A coding difficulty sometimes arises where a morphological diagnosis contains two qualifying adjectives that have different code numbers. An example is "transitional cell epidermoid carcinoma". "Transitional cell carcinoma NOS" is M8120/3 and "epidermoid carcinoma NOS" is M8070/3. In such circumstances, the higher number (M8120/3 in this example) should be used, as it is usually more specific.[5]

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, **malignant,** primary site

Malignant neoplasm without specification of site

~~C80 Malignant neoplasm without specification of site~~ C80.9 Malignant neoplasm, primary site unspecified 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~~ C79.9 Secondary malignant neoplasm, unspecified site should be ~~used~~ assigned 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~~ C79.9 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

[5] Refer to the note below morphology of neoplasms in the WHO ICD-10 Tabular List (Volume 1)

SDX: M8000/3 Neoplasm, malignant, primary site
SDX: ~~C80 Malignant neoplasm without specification of site~~ C79.9 Secondary malignant neoplasm, unspecified site
SDX: M8000/6 Neoplasm, malignant, metastatic site

Example 2:
Metastatic cancer of the pleura

PDX: ~~C80 Malignant neoplasm without specification of site~~ C80.9 Malignant neoplasm, primary site unspecified
SDX: 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~~ C79.9 Secondary malignant neoplasm, unspecified site should be assigned ~~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~~ C79.9 Secondary malignant neoplasm, unspecified site
SDX: ~~M8000/6 Neoplasm, malignant, metastatic site~~ M8010/6 Carcinoma, **NOS, malignant,** metastatic **site**
SDX: ~~C80 Malignant neoplasm without specification of site~~ C80.9 Malignant neoplasm, primary site unspecified
SDX: ~~M8000/3 Neoplasm, malignant, primary site~~ M8010/3 Carcinoma, NOS**, malignant, primary site**

Common Sites of Metastases[6]
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~~ C80.9 Malignant neoplasm, primary site unspecified 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

[6] WHO, ICD-10 Instruction Manual (Volume 2)

- 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~~ C80.9 Malignant neoplasm, primary site unspecified
M8000/3 Neoplasm, malignant, primary site
SDX: C78.7 Secondary malignant neoplasm of liver **and intrahepatic bile duct**
M8000/6 Neoplasm, malignant, metastatic 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, **malignant,** primary site **(C46.–)**

"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~~ lung
PDX: ~~C80 Malignant neoplasm without specification of site~~ C80.9 Malignant neoplasm, primary site unspecified
SDX: ~~M8000/3 Neoplasm, malignant, primary site~~ M8010/3 Carcinoma**,** NOS, malignant, primary site
SDX: ~~C79.8 Secondary malignant neoplasm of other specified sites~~ C78.0 Secondary malignant neoplasm of lung
SDX: ~~M8000/6 Neoplasm, malignant, metastatic site~~ M8010/6 Carcinoma, NOS, 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, **malignant,** primary site

Coding of radiotherapy and chemotherapy treatment for neoplasms

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, **NOS,** 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
M9080/3 Teratoma, **NOS,** malignant, primary site~~, NOS~~

Uncertain / Unknown Behaviour (rarely used)

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
M9989/1 Myelodysplastic syndrome NOS, uncertain whether benign or malignant (D46.9)

~~**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)~~

DSN0202 **Coding of Gastrointestinal Stromal Tumours**

Assign the appropriate morphology code for ~~neoplasm NOS until the MIT is updated to include the morphology codes for~~ the gastrointestinal stromal tumour~~s~~.

~~M8000/0 Neoplasm, benign~~
~~M8000/1 Neoplasm, uncertain whether benign or malignant~~
~~M8000/3 Neoplasm, malignant, primary site~~
~~M8000/6 Neoplasm, malignant, metastatic site~~

M8936/0 Gastrointestinal stromal tumour, benign
M8936/1 Gastrointestinal stromal tumour, NOS, uncertain whether benign or malignant
M8936/3 Gastrointestinal stromal sarcoma, malignant, primary site
M8936/6 Gastrointestinal stromal sarcoma, malignant, metastatic site

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

DSN0301 Anaemia due to Chronic Renal Failure

Coding of anaemia due to chronic renal failure:

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~~ kidney disease, unspecified
SDX: D63.8* Anaemia in other chronic diseases classified elsewhere

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DSN0302 Coding Haemophilia with 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[7]. ~~Refer to point (f) below chapter XVIII in the tabular list (volume 1)~~.

[7] WHO, ICD-10 Tabular List (Volume 1), refer to point (f) below chapter XVIII

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

DSN0401 ~~Non-insulin dependent~~ Type 2 diabetic who requires insulin

There is currently no appropriate ICD-10 ~~classification~~ **code** for a ~~non-insulin dependent~~ **type 2,** 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~~ **Type 2** diabetes mellitus should be ~~used~~ **assigned** as the South African standard and specified to the appropriate 4th character [E11.–] **for patients who receive insulin periodically as part of their treatment regime**.

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[8].
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[2]): Fee for procedure +50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists[9].~~

~~[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.[10]

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

[8] Extract from the minutes of the ICD-10 Technical Subcommittee meeting held on May 31, 2006
[9] ~~Reference – Medical Practitioner's Guide to Fees, 2006~~
[10] Extracted from NCCH ICD-10-AM, July 2002, Endocrine, Nutritional and Metabolic Diseases and the Australian Coding Standards, Third Edition, ICD-10 AM

DSN09 Diseases of the circulatory system (I00 – I99)

DSN0901 Coding of the Circulatory System

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.

Hypertension and renal disease or conditions

Guideline
Block category I12
Code conditions from N18.– as additional codes as they provide valuable information

Example 1:
Hypertensive end stage renal failure
PDX: I12.0 Hypertensive renal disease with renal failure
SDX: N18.~~0~~5 ~~End-stage renal disease~~ Chronic kidney disease, stage 5

Example 2:
Patient admitted with hypertension, chronic renal failure and congestive heart failure.
PDX: I12.0 Hypertensive renal disease with renal failure
SDX: N18.9 Chronic ~~renal failure~~ kidney disease, unspecified
SDX: I50.0 Congestive heart failure

I15 Secondary hypertension
This is hypertension resulting from another condition.

- Assign a code from this category when there is mention of "hypertension secondary to" or "hypertension due to".
- Assign a code for the underlying condition that caused the hypertension.
- I15.– should be assigned as an additional code unless the secondary hypertension is the reason for medical care or the main condition treated.
- I15.– can be assigned as the primary diagnosis if there is no information available regarding the underlying condition.

Example:
Patient is admitted for treatment of renovascular hypertension due to chronic renal failure.

PDX: I15.0 Renovascular hypertension
SDX: N18.9 Chronic ~~renal failure~~ kidney disease, unspecified

Ischaemic Heart Diseases (I20 – I25)

I21 Acute myocardial infarction

I21.– classifies ~~the first~~ an acute myocardial infarction. ~~This code can only be assigned once in a **lifetime** for a patient's first MI. It does not matter where the new acute MI is or what the time period is since the previous MI. If code I21._ has been used before or the clinician indicates that the patient has had a~~

~~previous MI, I21._ cannot be assigned.~~

A patient re-admitted within four weeks of having an acute myocardial infarction may still have an acute ischaemic heart condition. The coder should ascertain from the clinician the specific condition.

- If the clinician considers the ischaemic condition to be chronic, then, code **I25.8 Other forms of chronic ischaemic heart disease** ~~would~~ should be ~~appropriate~~ assigned.
- If not chronic, it will be a subsequent MI and a code~~d~~ from **I22.– Subsequent myocardial infarction** should be assigned.

I22 Subsequent myocardial infarction

I22.– Classifies any subsequent current acute myocardial infarction and should be assigned for any subsequent current acute myocardial infarction. This category should be assigned for infarction of any myocardial site, occurring within four weeks (28 days) from onset of a previous infarction.

~~(~~I22 Classifies any subsequent MI, within the 4 weeks time period, even if the site~~s~~ differs, from the previous MI~~)~~.

~~**Note:** The acute MI code (I21._) must only be assigned once in a **lifetime** for a patient's first MI.~~
The terms **'recurrent'** and **'subsequent'** are utilised interchangeably or synonymously.

DSN10 Diseases of the respiratory system (J00 – J99)

DSN1008 Coding of A/H1N1 [swine flu] ~~(A/H1N1)~~

J09 Influenza due to certain identified ~~avian~~ influenza virus to be assigned for ~~(~~A/H1N1~~)~~ [swine flu]. ~~(A/H1N1) as per the WHO's recommendation~~.

DSN14 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~~ kidney disease, unspecified
SDX: Z49.1 Extracorporeal dialysis

DSN15 ~~Diseases of~~ Pregnancy, ~~C~~childbirth and the ~~P~~puerperium (O00 – O99)

DSN1501 Pregnancy with abortive outcome

Abortion

Example:
Patient admitted for a medical abortion at 22 weeks of gestation for suspected damage to foetus following a medical procedure. This resulted in the delivery of a single live born infant.

PDX: O35.7 Maternal care for (suspected) damage to fetus by other medical procedures
SDX: O60.~~1~~3 Preterm ~~labour with preterm~~ delivery without spontaneous labour
SDX: O80.9 Single spontaneous delivery, unspecified
SDX: Z37.0 Single live birth

O06 Unspecified abortion

1. Direct cause (Direct Inadvertent Abortion)
Due to uterine surgery which will inevitably lead to an abortion.

- Assign code **O06.–** in the secondary position.

Example 1:
Hysterectomy performed for a uterine leiomyoma. Patient found to be pregnant.

PDX: D25.9 Leiomyoma of uterus, unspecified
SDX: M8890/0 Leiomyoma, NOS, benign
SDX: O06.9 Unspecified abortion, complete or unspecified, without complication

2. Indirect cause of Inadvertent Abortion
Patient known to be pregnant but undergoes treatment causing a spontaneous abortion which indirectly leads to the termination of the pregnancy:

- Assign code **O03.–** in the secondary position.

Example 1:
Pregnant patient admitted for acute appendicitis. Emergency appendectomy performed. Spontaneous abortion occurred one day later.

PDX: O99.6 Diseases of the digestive system complicating pregnancy, childbirth and the puerperium
SDX: K35.~~9~~8 Acute appendicitis, unspecified
SDX: O03.9 Spontaneous abortion, complete or unspecified, without complication

Interception of pregnancy

Code the interception of pregnancy to Z30.3 Menstrual extraction.

DSN1502 Pregnancy

HELLP syndrome (O14.~~1~~2)

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.

A code for eclampsia (O15.–) and a code for HELLP Syndrome (O14.~~1~~2) must be assigned if the patient presents with both conditions.

~~Footnote: A specific code for HELLP Syndrome will be available with the next ICD-10 update.~~

Coding of HELLP syndrome which resulted in a ruptured liver
Sequence O14.~~1~~2 ~~Severe pre-eclampsia~~ HELLP syndrome 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.

Codes from other chapters can be utilised in addition to codes from Chapter 15 to further describe a condition.

Example:
Patient is admitted for treatment of pre-existing insulin-dependent diabetes mellitus with ketoacidosis. She is 30 weeks pregnant.

PDX: O24.0 Pre-existing **type 1** diabetes mellitus~~, insulin-dependent~~
SDX: E10.1 ~~Insulin-dependent~~ **Type 1** diabetes mellitus with ketoacidosis

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DSN1503 **Labour and Delivery**

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 **spontaneous** labour with preterm delivery
Labour occurring before 37 completed weeks of pregnancy with a delivery

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

O60.3 Preterm delivery without spontaneous labour

Example:
Patient was admitted into hospital at 30 weeks of gestation due to premature labour. ~~Labour was delayed by pitocin therapy for two days~~. A tocolytic ~~Ritodrine~~ was administered to suppress contractions. 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 **spontaneous** labour with preterm delivery
SDX: O82.1 Delivery by emergency caesarean section
SDX: Z37.0 Single live birth

Coding of a delivery with premature rupture of membranes with chorioamnionitis

Example:
Patient admitted with premature rupture of membranes with chorioamnionitis and premature labour. Onset of labour noted as within 24 hours. Preterm delivery of live born.

PDX: O41.1 Infection of amniotic sac and membranes
SDX: O60.1 Preterm **spontaneous** labour with preterm delivery
SDX: O42.0 Premature rupture of membranes, onset of labour within 24 hours
SDX: O80.9 Single spontaneous delivery, unspecified
SDX: Z37.0 Single live birth

Coding of HIV / AIDS and Deliveries

Example 1(a):
A patient has an elective caesarean section and a live born infant is delivered. She is HIV positive.

PDX: ~~O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium~~ O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
SDX: O82.0 Delivery by elective caesarean section
SDX: Z37.0 Single live birth
SDX: Z21 Asymptomatic human immunodeficiency virus [HIV] infection status

Example 1(b):
A patient has an elective caesarean section and a live born infant is delivered. She is known to have HIV disease.

PDX: ~~O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium~~ O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
SDX: O82.0 Delivery by elective caesarean section
SDX: Z37.0 Single live birth
SDX: B24 Unspecified Human Immunodeficiency Virus [HIV] disease

Example 2:
A patient with HIV disease resulting in Slim disease has an elective caesarean section and a liveborn infant is delivered.

PDX: ~~O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium~~ O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
SDX: O82.0 Delivery by elective caesarean section
SDX: Z37.0 Single live birth
SDX: B22.2 HIV disease resulting in wasting syndrome

Example 3:
A patient with HIV disease has a normal vertex delivery with no complications. A live born infant is delivered

PDX: ~~O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium~~ O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
SDX: O80.0 Spontaneous vertex delivery
SDX: Z37.0 Single live birth
SDX: B24 Unspecified Human Immunodeficiency Virus [HIV] disease

Example 4:
A patient with HIV disease has an elective caesarean section. Outcome of delivery is a live born infant. The patient is known to have Kaposi sarcoma of the skin as a result of the HIV disease.

PDX: ~~O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium~~ O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
SDX: O82.0 Delivery by elective caesarean section
SDX: Z37.0 Single live birth
SDX: B21.0 HIV disease resulting in Kaposi~~'s~~ sarcoma
SDX: C46.0 Kaposi~~'s~~ sarcoma of skin
SDX: M9140/3 Kaposi~~'s~~ sarcoma, **malignant,** primary site **(C46.–)**

Coding of HIV/AIDS and Deliveries with Complications

Example 1:
Patient known to have HIV / AIDS developed puerperal sepsis following an elective caesarean section. Single live born infant delivered.

PDX: O85: Puerperal sepsis
SDX: ~~O98.5: Other viral diseases complicating pregnancy, childbirth and the puerperium~~ O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
SDX: B24: Unspecified human immunodeficiency virus [HIV] disease
SDX: O82.0: Delivery by elective caesarean section
SDX: Z37.0: Single live birth

Example 2:
If a patient with HIV/AIDS is admitted for a caesarean delivery of a single live-born and the patient complicates and is receiving treatment for the HIV/AIDS, the scenario will be coded as follows

PDX: ~~O98.5: Other viral diseases complicating pregnancy, childbirth and the puerperium~~ O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
SDX: B24: Unspecified human immunodeficiency virus [HIV] disease
SDX: O82.0: Delivery by elective caesarean section
SDX: Z37.0: Single live birth

~~**Footnote:**~~
~~The code O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium will be used until the next ICD-10 update. The new code for Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium is classified to the category O98 Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium.~~

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

DSN1602 Conditions originating in the perinatal and neonatal period

Perinatal Period
The perinatal period commences at 22 completed weeks (154 days) of gestation (the time when birth weight is normally 500g) and ends seven completed days after birth[11].

~~Footnote:~~ ~~Certain conditions in the neonatal period will be coded to Chapter XVI~~

[11] Certain conditions in the neonatal period will be coded to Chapter XVI of the WHO, ICD-10 Tabular List (Volume 1)

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

Guidelines when using sign and symptom codes e.g. R-codes

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

Example 1:
Known diabetic admitted for hyperglycaemia
PDX: E10.– to E14.– Diabetes mellitus
SDX: R73.9 Hyperglycaemia, unspecified

DSN1802 Systemic Inflammatory Response Syndrome (SIRS)

R65 Systemic Inflammatory Response Syndrome
Note: This category should never be used in primary coding. The category is for use in multiple coding to identify this condition resulting from any cause. A code from another chapter should be assigned first to indicate the cause or underlying disease.[12]

Example 1:
Patient admitted with pancreatitis and developed SIRS.

PDX: K85.9 Acute pancreatitis, unspecified
SDX: R65.9 Systemic Inflammatory Response Syndrome, unspecified

[12] Reference: WHO ICD-10, Volume 1

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

DSN1905 Coding Injuries

Sequencing rules when coding injuries[13]
~~[Reference Volume 2, First Edition, page 123 or Second Edition, page 129]~~

Open and Closed Injuries[14]

An open wound is a type of injury where the skin has been penetrated. The skin is torn, cut or punctured. Open wounds include e.g. an animal bite, a cut, a laceration and a puncture wound.

2.4.6 Supplementary subdivisions for use at the fifth or subsequent character level.
Chapter XIX – subdivisions to indicate open and closed fractures as well as intracranial, intrathoracic and intra-abdominal injuries with **and** ~~or~~ without open wound.[15]

Refer to **GSN**0006 **Level of Coding** regarding the use of the fifth character code.

A fifth character of "1 – open" will be assigned if there has been penetration of the skin **communicating with a fracture or a dislocation or injuries where an internal body cavity has been punctured exposing the cavity e.g.** ~~for~~ intracranial wounds, intra-thoracic wounds, intra-abdominal and intra-pelvic wounds.

Example 1:
Patient sustained a closed fracture of the neck of femur following a fall down the stairs.

PDX: S72.00 Fracture of neck of femur, closed
SDX: W10.99 Fall on and from stairs and steps, unspecified place, during unspecified activity

Example 2:
Patient sustained an injury of the kidney following a motor vehicle accident

PDX: S37.00 Injury of kidney, without open wound into cavity
SDX: V89.29 Person injured in unspecified motor-vehicle accident, traffic, during unspecified activity

Example 3:
Patient sustained an open fracture of the upper end of the radius.

PDX: S52.11 Fracture of upper end of radius, open
SDX: X59.09 Exposure to unspecified factor causing fracture, during unspecified activity

Example 4:
Patient sustained an injury of the spleen with an open wound into the intra-abdominal cavity.

[13] WHO, ICD-10 Instruction Manual (Volume 2)
[14] Refer to 2.4.6 in the WHO, ICD-10 Instruction Manual (Volume 2) and notes below Chapter XIX in the WHO, ICD-10 Tabular List (Volume 1)
[15] Reference: WHO ICD-10, Volume 2

PDX: S36.01 Injury of spleen, with open wound into cavity
SDX: X59.99 Exposure to unspecified factor causing other and unspecified injury, during unspecified activity

DSN1906 **Complications of Surgery and Medical Care**

Existing condition

Example:
Patient admitted with a diabetic ulcer of the lower limb. Known type II DM.

PDX: E11.5 ~~Non-insulin-dependent~~ **Type 2** diabetes mellitus with peripheral circulatory complications
SDX: L97 Ulcer of lower limb, not elsewhere classified

* *The doctor does not have to state that it is a complication of the DM*

Misadventure
~~An instance of misfortune; a mishap; error in surgery or other fields of medicine.~~
A misadventure is an instance of misfortune, a mishap, an error in surgery or other fields of medicine.

Whenever a complication of a procedure is not indexed or is not a synonym of an inclusion or indexed term, proceed as follows[16]:

Code to T80 – T88:
- early complications of medical procedure;
- mechanical complications;

Code to appropriate system chapter:
- late complications;
- functional complications;

~~**See notes in Volume 3, under the lead term "Complications"**~~

~~**Footn**~~ **Note:**

1. The fact that the problem is a complication due to a procedure / medical care must be documented by the clinician / service provider; the coder cannot make this determination.

2. Note that not all conditions that occur following medical care / surgery are classified as complications. There must be more than a routinely expected condition or occurrence. There must be a cause-and-effect relationship between the care provided and the condition, and some indication that it is a complication.

3. Note that the term complication does not imply that improper or inadequate care is responsible for the complication.

4. Be aware of the difference between a complication and sequelae of a complication.

5. No time limit is defined for the development of a complication. It may occur during the hospital episode in which the care was provided, shortly thereafter, or even years later.

[16] Refer to notes below the lead term "Complications" in the WHO, ICD-10 Alphabetical Index (Volume 3)

6. When a patient is re-admitted with a complication following a previous treatment/procedure, that admission is treated as a new episode and therefore the complication as the reason for admission may be the primary diagnosis.

DSN1907 **Follow-up care involving removal of fracture plate and other internal fixation device**

Z47.0 Follow-up care involving removal of fracture plate and other internal fixation device should be assigned as the primary diagnosis for the routine removal of the fracture plate or internal fixation device.

If the patient is admitted with a complication or a sequelae of the fracture then assign the appropriate codes.

Refer to definition of “current injury” and “old injury” (**DSN**1905 **Coding Injuries**).

Example:
Patient admitted with a malunion following a fracture of the radius.

PDX: M84.03 Malunion of fracture, forearm
SDX: T92.1 Sequelae of fracture of arm
SDX: Y89.9 Sequelae of unspecified external cause code

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

DSN2001 External Cause Codes

Guideline for External Cause Codes Y40 – Y84

Y40.0 Penicillins
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
These codes are being used incorrectly to indicate that some form of anaesthetic was administered.~~; the intention of t~~ These codes ~~is actually to~~ indicate "~~D~~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 **ICD-10** Master Industry Table (MIT).

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 travel**l**ing home from work.

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

~~Footn~~ Note:

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 travel**l**ing home from work. The~~is~~ 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 travel**l**ing 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
~~Footn~~ Note:
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.

DSN21 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.

When a sign and / or symptom is the reason for the examination, assign an appropriate code for the sign and / or symptom when no abnormality is detected.

Example 1:
Patient for a Computerised Axial Tomography (CAT) scan of the head, presenting with severe headaches. **R51 Headache** was assigned as per referral note from the General Practitioner.~~, 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.

PDX: R51 Headache
SDX: Z03.9 Observation for suspected disease or condition, unspecified

Example 2:
Patient for a Computerised Axial Tomography (CAT) scan of the head.

PDX: Z01.6 Radiological examination, not elsewhere classified

Example 3:
Patient for a Computerised Axial Tomography (CAT) scan of the head. No abnormalities detected on the scan.

PDX: Z01.6 Radiological examination, not elsewhere classified
SDX: Z03.9 Observation for suspected disease or condition, unspecified

Refer to example 3 at **DSN**2135 **Special Screening examination**.

DSN2102 Routine Examination, Radiology

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

Refer to examples at **DSN**2135 **Special Screening examination**.

DSN2103 **Routine Examination, Pathology**

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

Refer to examples at **DSN**2135 **Special Screening examination**.

Z01.7 Laboratory Examination is the appropriate code to assign in clinical pathology where a definite diagnostic code cannot be determined from the result/s.

This code is not to be used for histopathology and cytopathology findings.

DSN2106 **Emergency Radiology** – removed

~~**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.~~

DSN2111 **Frames sold without lenses being fitted**

Code ~~**Z41.9 Procedure for purposes other than remedying health state, unspecified**~~ **Z46.0 Fitting and adjustment of spectacles and contact lenses** is the appropriate code for use when frames are sold without lenses being fitted.

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

~~**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).~~

DSN2117 **Sports Mouth Guard** – removed

~~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.~~

DSN2121 Finding and a Routine X-ray – removed

~~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 X-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~~

DSN2122 **After hours radiological investigations** – removed

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

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.[17]

The following codes may be used should a fracture occur:

PDX: T88.8 Other specified complications of surgical and medical care, not elsewhere classified
SDX: Y84.8 Abnormal reaction / later complication: other medical procedures

If a Sequela
PDX: T98.3 Sequelae of complications of surgical and medical care, not elsewhere classified
SDX: Y88.2 Sequela of adverse incidents associated with medical devices in diagnostic and therapeutic use

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DSN2125 **Issues of Consent** – removed

~~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.~~

DSN2126 Repair of a Hearing Device

The condition requiring the hearing aid ~~w~~should be ~~cod~~ assigned 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.

DSN2127 **Transport of Blood**

~~Code~~ Assign **Z51.3 Blood transfusion without reported diagnosis** and the appropriate ~~NH~~RPL code to represent the transport of blood.

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[17] Definition of a Post – Dr Neil Campbell

DSN2128 **Coding for Microbiology** – removed

~~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~~

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 assigned should be for the condition resulting in the patient requiring terminal care. The terminal care code should be assigned ~~coded~~ as the secondary code.

Example:
Patient terminally ill with AIDS

PDX: B24 Unspecified human immunodeficiency virus [HIV] disease
SDX: Z51.5 Palliative care

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**n** 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
SDX: Z20.6 Contact with and exposure to human immunodeficiency virus [HIV]
SDX: Z29.8 Other specified prophylactic measures

Example 2:
Health care worker prescribed PEP. She sustained a needle stick injury to her finger following administration of an injection to a 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
SDX: Z29.8 Other specified prophylactic measures

Example ~~2~~3:
Patient for PEP, information not disclosed to the pharmacy dispensing the PEP.

PDX: Z29.8 Other specified prophylactic measures

Example ~~3~~4:
Patient for ARV prophylaxis following exposure to blood. Blood spattered into her eyes while working. WCA (Workman's compensation) form completed.

PDX: Z57.8 Occupational exposure to other risk-factors
SDX: X58.92 Exposure to other specified factors, unspecified place, while working for income
SDX: 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.

DSN2131 **Coding of Rehabilitation**

When a patient is admitted for rehabilitation, the primary diagnosis code assigned should be for the condition resulting in the patient requiring rehabilitation. The rehabilitation code should be assigned ~~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

DSN2132 **Coding for Dental Laboratories**

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

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DSN2134 **The use of History Codes**

Personal History Z85 – Z88

Personal History codes are reported to indicate the need for adjunctive surgery and treatment. These codes describe circumstances that influence the person's health status but are not a **current illness or injury**. They do not describe the main condition treated / primary diagnosis, but rather provide an item of information about the state of the patient.
These codes ~~will~~ should not be assigned as the PDX. They may be assigned as additional diagnoses when the condition is completely resolved but the history of the condition is relevant to the current episode of care.

DSN2139 **Prophylactic drug administration in newborns**

Assigning of codes for the administration of prophylactic drugs in newborns where no diagnosis is made.

Example 1:
Prophylactic antibiotics administered to newborn, born in hospital. No specific diagnosis made.

PDX: Z38.0 Singleton, born in hospital

SDX: Z29.2 Other prophylactic chemotherapy

Example 2:
Prophylactic antibiotics administered to newborn, born in hospital. Newborn observed for possible infection. No specific diagnosis made.

PDX: Z03.8 Observation for other suspected diseases and conditions
SDX: Z29.2 Other prophylactic chemotherapy
SDX: Z38.0 Singleton, born in hospital

DSN2140 **Removal of a urethral and ureteral stent**

The appropriate code to assign for the removal of a urethral or ureteral stent is **Z46.6 Fitting and adjustment of urinary device** unless there is a specific reason for the removal e.g. a malfunction or a complication of the stent.

DSN2141 **Dependence on enabling machines and devices**

Z99.1 Dependence on respirator
A code for dependence on a respirator or ventilator should only be assigned in the following instances:

- For all ventilation outside of theatre
- Where a patient collapses in theatre and is transferred to the Intensive Care Unit (ICU)
- Long term admissions that require ventilation
- Patients who are dependent on ventilation at home, in a frail care unit or step down facilities etc.

Do not assign codes for short term ventilation e.g. theatre admissions

Z99.2 Dependence on renal dialysis
Refer to **DSN**1401 **Coding of Dialysis** and **DSN**2134 **The use of History Codes**.

DSN22 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.

~~**Footn** **Note**~~**:**
The 5th character indicates whether drug resistance is primary or secondary as follows[18]:
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.phisc.org.za/~~

DSN2203 ~~Bacterial agents resistant to antibiotics (U80 – U89)~~ Resistance to antimicrobial and antineoplastic drugs (U82-U85)

~~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.~~

Note: These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify the resistant properties of infectious agent(s), which are themselves 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**~~

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[18] Reference: Document compiled by Nelson Nagoor, Igolide Health Networks, published on the PHISC website http://www.phisc.org.za/

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

U82 Resistance to betalactam antibiotics
U82.0 Resistance to penicillin
U82.1 Resistance to methicillin
U82.2 Extended spectrum betalactamase (ESBL) resistance
U82.8 Resistance to other betalactam antibiotics
U82.9 Resistance to betalactam antibiotics, unspecified

U83 Resistance to other antibiotics
U83.0 Resistance to vancomycin
U83.1 Resistance to other vancomycin related antibiotics
U83.2 Resistance to quinolones
U83.7 Resistance to multiple antibiotics
U83.8 Resistance to other single specified antibiotic
U83.9 Resistance to unspecified antibiotic

U84 Resistance to other antimicrobial drugs
U84.0 Resistance to antiparasitic drug(s)
U84.1 Resistance to antifungal drug(s)
U84.2 Resistance to antiviral drug(s)
U84.3 Resistance to tuberculostatic drug(s)
U84.7 Resistance to multiple antimicrobial drugs
U84.8 Resistance to other specified antimicrobial drug
U84.9 Resistance to unspecified antimicrobial drugs

U85 Resistance to antineoplastic drugs

DSN2204 **Drug Resistant HIV**

~~Footnote~~: ~~These codes are currently not on the Master Industry Table (MIT) and therefore not valid. They will be updated with the next MIT update.~~

DSN2205 **Emergency use of U06 and Emergency use of U07**

This range of codes should not be used in the South African environment unless recommended by the WHO.

These codes have not been adopted for use in South Africa.

DSN2206 **Resistance to antiviral drug(s)**

Please refer to **DSN**2204 **Drug Resistant HIV** before assigning U84.2 Resistance to antiviral drug(s) for drug resistant HIV.

DSN2207 **Resistance to tuberculostatic drug(s)**

Please refer to **DSN**2201 **Drug resistant tuberculosis** before assigning U84.3 Resistance to tuberculostatic drug(s).

References

Frans Vorster
~~Codemedix~~
Code Medix

Dr. Noluthando Nematswerani
Discovery