



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

The South African ICD-10 Morbidity Coding Standards and Guidelines

Developed to assist the Clinical Coder in the South African environment

Date: April 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.

Table of Contents

Acknowledgement	5
Introduction	5
User Guide.....	5
South African Code of Ethics for Clinical Coders	6
General Morbidity Coding Standards and Guidelines	8
GSN0001 Primary Diagnosis	9
GSN0002 Secondary Diagnosis/es.....	9
GSN0003 ICD-10 Codes on Claims.....	10
GSN0004 Submission of claims.....	10
GSN0005 ICD-10 Subsets	10
GSN0006 Level of Coding.....	10
GSN0007 The use of the Non-disclosure codes (U98).....	11
GSN0008 Updating ICD-10 Codes	11
GSN0009 The “X” in place of a fourth character.....	11
GSN0010 Dagger and Asterisk Symbols	12
GSN0011 Inappropriate use of fifth [5th] character options.....	12
GSN0012 Appropriate codes to be used together with medical practitioner service codes for the completion of forms, scripts and motivations.....	12
GSN0013 Coding of Syndromes.....	13
GSN0014 Updating of the SA ICD-10 Morbidity Coding Standards and Guidelines Document	13
GSN0015 Sequelae (Late Effects).....	16
GSN0016 Dagger and asterisk system / convention	16
GSN0017 ICD-10 Coding for mixtures on medicine claims	17
General Standards related to Claims	18
GSN0101 Mandatory Inclusion of ICD-10 Codes on Claims	19
GSN0102 Submission of Claims.....	19
GSN0103 Paper and Electronic Claims containing ICD-10 Codes	20
GSN0104 Paper Claims containing ICD-10 Codes	21
GSN0105 Electronic Claims containing ICD-10 Codes	21
Diagnosis Standards.....	24
DSN01 Certain infectious and parasitic diseases (A00 – B99)	26
DSN0101 HIV / AIDS	26
DSN0102 Coding prophylactic administration of anti-malaria drugs.....	31
DSN0103 Coding of infections with drug resistant micro-organisms.....	31
DSN0104 Coding of other infections.....	31
DSN0105 Coding diarrhoea and gastroenteritis without further specification	31
DSN0106 Coding of Retroviral Disease (RVD).....	32
DSN02 Neoplasms (C00 – D48)	33
DSN0201 Neoplasm Coding	33
DSN0202 Coding of Gastrointestinal Stromal Tumours	41
DSN03 Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50 – D89).....	42
DSN0301 Anaemia due to Chronic Renal Failure	42
DSN0302 Coding Haemophilia with Epistaxis	42
DSN04 Endocrine, nutritional and metabolic diseases (E00 – E90)	43
DSN0401 Type 2 diabetic who requires insulin	43
DSN0402 Obesity.....	43
DSN05 Mental and behavioural disorders (F00 – F99).....	44
DSN0501 Mental and behavioural disorders due to alcohol, drug and tobacco use	44
DSN09 Diseases of the circulatory system (I00 – I99).....	46
DSN0901 Coding of the Circulatory System	46
DSN10 Diseases of the respiratory system (J00 – J99).....	52
DSN1001 Coding of both sinusitis and bronchitis	52
DSN1002 Bronchitis	52
DSN1003 Avian Flu.....	52
DSN1004 Coding Chronic Obstructive Pulmonary Disease (COPD) / Chronic Obstructive Airways Disease (COAD) and Emphysema.....	52

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

DSN1005 Coding Chest Infection	52
DSN1006 Coding prophylactic administration Palivizumab (Synagis®)	53
DSN1007 Community acquired pneumonia.....	53
DSN1008 Coding of A/H1N1 [swine flu].....	53
DSN11 Diseases of the digestive system (K00 – K93)	54
Guideline when coding degenerative leiomyopathy.....	54
DSN12 Diseases of the skin and subcutaneous tissue (L00 – L99)	55
DSN1201 Cosmetic surgery for skin laxity following weight loss.....	55
DSN13 Diseases of the musculoskeletal system and connective tissue (M00 – M99).....	56
DSN1301 Necrotizing Fasciitis – removed.....	56
DSN1302 Subsequent hip replacement following an old hip replacement	56
DSN1303 Osteopaenia	56
DSN1304 Coding of Osteoarthritis.....	56
DSN1305 Site of musculoskeletal involvement	56
DSN14 Diseases of the genitourinary system (N00 – N99)	58
DSN1401 Coding of Dialysis.....	58
DSN15 Pregnancy, childbirth and the puerperium (O00 – O99).....	59
DSN1501 Pregnancy with abortive outcome	59
DSN1502 Pregnancy.....	63
DSN1503 Labour and Delivery	65
DSN1504 Puerperium	69
Guideline when submitting a claim for a breast pump	70
DSN1505 Other Obstetric Conditions	70
DSN16 Certain conditions originating in the perinatal period (P00 – P96)	72
DSN1601 Neonatal Bronchiolitis.....	72
DSN1602 Conditions originating in the perinatal and neonatal period	72
DSN1603 Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00 – P04).....	73
DSN1604 Disorders related to short gestation and low birth weight, not elsewhere classified (P07) ...	73
DSN1605 Fetal death of unspecified cause (P95).....	73
DSN18 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00 – R99)	74
.....	74
Guidelines when using sign and symptom codes e.g. R-codes.....	74
DSN1801 Coding a Death.....	75
DSN1802 Systemic Inflammatory Response Syndrome (SIRS)	75
DSN19 Injury, poisoning and certain other consequences of external causes (S00 – T98).....	76
DSN1901 Poisoning, Overdose and Adverse Effects.....	76
Poisoning.....	76
Overdose.....	76
Adverse Effects	77
DSN1902 Unregistered and trial Drugs.....	77
DSN1903 Herbal Enemas.....	77
DSN1904 Sexual harassment at the workplace	78
DSN1905 Coding Injuries.....	78
Current Injury.....	80
Old Injury	80
Open and Closed Injuries.....	80
DSN1906 Complications of Surgery and Medical Care	82
DSN1907 Follow-up care involving removal of fracture plate and other internal fixation device	84
DSN20 External causes of morbidity and mortality (V01 – Y98).....	86
DSN2001 External Cause Codes.....	86
Undetermined Intent.....	86
External Cause Codes (ECC's) – Public Road	86
External Cause Codes (ECC's) – Minibus	86
External Cause Codes (ECC's) – Quad Bike.....	86
External Cause Codes (ECC's) – Hijacking.....	86
Guideline for External Cause Codes Y40 – Y84	86
Place of Occurrence “5 Trade and Service area”	87
Definitions related to transport accidents	87

DSN2002 Coding for Compensation for Occupational Injuries and Diseases Act (COIDA).....	88
DSN21 Factors influencing health status and contact with health services (Z00 – Z99).....	90
DSN2101 Code for No Abnormalities Detected.....	90
DSN2102 Routine Examination, Radiology.....	90
DSN2103 Routine Examination, Pathology.....	90
DSN2104 Diagnosis for Rule D, Cancellation of appointments.....	91
DSN2105 Routine Dental Examination.....	91
DSN2106 Emergency Radiology – removed.....	91
DSN2107 Non-surgical Prophylactic Measures.....	91
DSN2108 Consultation, taking patient history from a family member.....	91
DSN2109 Re-cementation of a Crown / Bridge.....	92
DSN2110 Repair of a Denture.....	92
DSN2111 Frames sold without lenses being fitted.....	92
DSN2112 Repairs and Adjustments to appliances.....	92
DSN2113 Repeat prescription for spectacles.....	92
DSN2114 Binocular Vision Therapy.....	92
DSN2115 Pharmacy Standards.....	92
DSN2116 ICD-10 Codes linked to each material code per line – removed.....	93
DSN2117 Sports Mouth Guard – removed.....	93
DSN2118 Routine Bone Density Test / Densitometry.....	93
DSN2119 Routine Newborn Examinations.....	93
DSN2120 Antenatal Classes.....	93
DSN2121 Finding and a Routine X-ray – removed.....	93
DSN2122 After hours radiological investigations – removed.....	93
DSN2123 Posts.....	93
DSN2124 Z – codes Invalid in the Primary Position.....	94
DSN2125 Issues of Consent – removed.....	94
DSN2126 Repair of a Hearing Device.....	94
DSN2127 Transport of Blood.....	94
DSN2128 Coding for Microbiology – removed.....	94
DSN2129 Coding of Terminal Care.....	94
DSN2130 Post Exposure Prophylaxis (PEP).....	94
DSN2131 Coding of Rehabilitation.....	95
DSN2132 Coding for Dental Laboratories.....	96
DSN2133 Coding results of HIV tests.....	96
DSN2134 The use of History Codes.....	96
DSN2135 Special Screening examination.....	98
DSN2136 Surgery not performed.....	99
DSN2137 Blood test for DNA.....	99
DSN2138 Liveborn infants according to place of birth (Z38).....	99
DSN2139 Prophylactic drug administration in newborns.....	100
DSN2140 Removal of a urethral and ureteral stent.....	100
DSN2141 Dependence on enabling machines and devices.....	100
DSN22 Codes for special purposes (U00 – U99).....	101
DSN2201 Drug resistant tuberculosis.....	101
DSN2202 Non-disclosure.....	102
DSN2203 Resistance to antimicrobial and antineoplastic drugs (U82 – U85).....	102
DSN2204 Drug Resistant HIV.....	102
DSN2205 Emergency use of U06 and Emergency use of U07.....	103
DSN2206 Resistance to antiviral drug(s).....	103
DSN2207 Resistance to tuberculostatic drug(s).....	103
Summary of changes made to the South African ICD-10 Morbidity Coding Standards and Guidelines document.....	104
Coding Definitions.....	104
Quick Reference Code Lists (QRC).....	104
Routine.....	104
Abbreviations.....	105
References.....	106

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The South African ICD-10 Morbidity Coding Standards and Guidelines for coding in the South African environment have been agreed and compiled by the ICD-10 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.

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

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 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 choice¹.

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.

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

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

GSN0001

GSN – General Standard National

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 – Diagnosis Standard National

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

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

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

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

GSN0001

GSN – General Standard National

GSN00 Encompasses General Standards for Diseases

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

GSN0001 Primary Diagnosis²

The primary diagnosis or main condition is defined as follows:

1. 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".
2. If there is more than one "main condition treated", then the most clinically severe or life threatening condition should be selected.
3. If this cannot be established then the condition held most responsible for the greatest use of resources³ should be selected.
4. The coder should revert to the default rule that allows the selection of the first condition recorded by the responsible clinician in circumstances where there is more than one "main condition" treated and no information is available to determine which of the conditions is the most severe or life threatening, or which one is responsible for the greatest use of resources.
5. If no diagnosis was made, the main symptom, abnormal finding or problem should be selected as the "main condition".
6. 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".

GSN0002 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

² 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.

³ 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.

- 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 – 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

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.

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.

GSN0003 ICD-10 Codes on Claims

This standard has been replaced by **GSN0101 Mandatory Inclusion of ICD-10 Codes on Claims**.

GSN0004 Submission of claims

This standard has been replaced by **GSN0102 Submission of Claims**.

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.

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 Occupational 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.

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.

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”

GSN0007 The use of the Non-disclosure codes (U98)

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.

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.

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 update, should the situation warrant it.

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.

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.

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.

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.

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

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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

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 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.

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

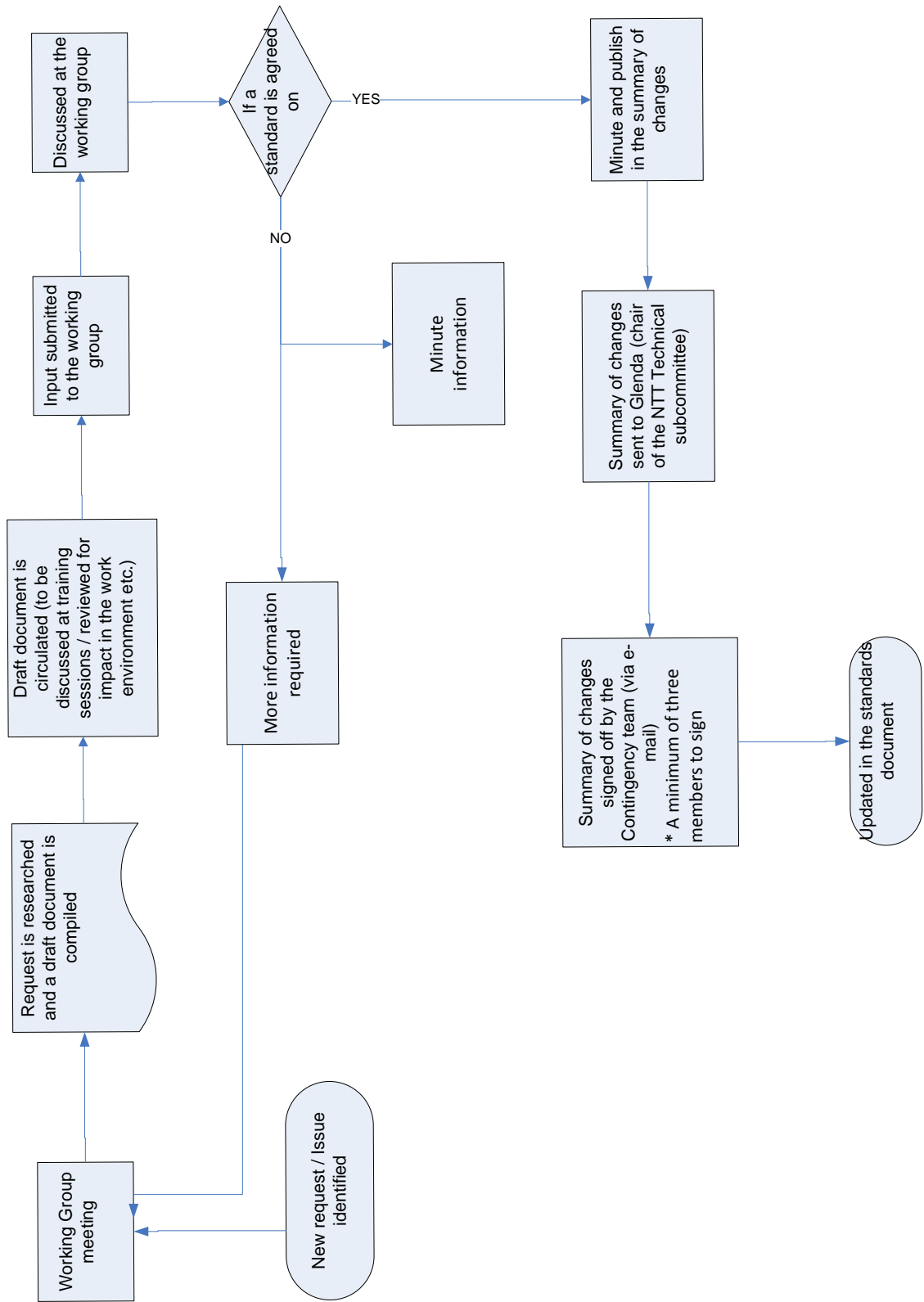
A summary of changes will be compiled and included in the SA ICD-10 Morbidity Coding standards and Guidelines document after each update.

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 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.

Appendix A



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 causal 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 causal 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).

GSN0016 Dagger and asterisk system / convention⁴

The dagger is the underlying condition (symbol +) and the asterisk (symbol *) is the manifestation.

1) If the symbol (+) and the alternative asterisk code both appear in the rubric heading, all terms classifiable to that rubric are subject to dual classification and all have the same alternative code, e.g. A17.0+ Tuberculous meningitis (G01*)

A17.0+ Tuberculous meningitis (G01*)

Tuberculosis of meninges (cerebral) (spinal)
Tuberculous leptomeningitis

- These codes are marked as dagger codes on the Master Industry Table (MIT).

2) If the symbol appears in the rubric heading but the alternative asterisk code does not, all terms classifiable to that rubric are subject to dual classification but they have different alternative codes (which are listed for each term), e.g. A18.0+ Tuberculosis of bones and joints

A18.0+ Tuberculosis of bones and joints

Tuberculosis of:

- hip (M01.1*)
- knee (M01.1*)
- vertebral column (M49.0*)

- These codes are marked as dagger codes on the Master Industry Table (MIT).

⁴ Refer to 3.1.3, the “dagger and asterisk system” in the WHO, ICD-10 Instruction Manual (Volume 2) The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

3) If neither the symbol nor the alternative code appear in the title, the rubric as a whole is not subject to dual classification but individual inclusion terms may be; if so, these terms will be marked with the symbol and their alternative codes given, e.g. A54.8 Other gonococcal infections

A54.8 Other gonococcal infections

Gonococcal:

- brain abscess+ (G07*)
- endocarditis+ (I39.8*)
- meningitis+ (G01*)

➤ These codes are not marked as dagger codes on the Master Industry Table (MIT).

This may also occur if the asterisk code indicates a link e.g. **M90.7_* Fracture of bone in neoplastic disease (C00 – D48+)**

Dagger codes not flagged to asterisk codes on the ICD-10 Master Industry Table (MIT)

Not all possible dagger codes are flagged to asterisk codes or with their asterisk combinations in the ICD-10 Master Industry Table (MIT). These combinations must be applied if 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 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.

GSN0017 ICD-10 Coding for mixtures on medicine claims

Each component of a mixture must be reported on a separate line and each line must have an ICD-10 code on a claim.

General Standards related to Claims

GSN0101

GSN – General Standard National

GSN01 Encompasses 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 providers**, 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.

GSN0101 Mandatory Inclusion of ICD-10 Codes on Claims replaces GSN0003 ICD-10 Codes on Claims

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.

GSN0102 Submission of Claims replaces **GSN0004 Submission of claims**

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 K35.8:

Incorrect submission: K358
Correct submission: K35.8
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.

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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_8
Correct submission: M79.20_/I15.0_/K35.8

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

Incorrect submission: M79-20/I15-0/K35-8
Correct submission: M79.20_/I15.0_/K35.8

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

Incorrect submission: (M79.20)(I15.0)(K35.8)
Correct submission: M79.20_/I15.0_/K35.8

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.

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

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.

Example 1

Claim

KYE MEDICAL SPECIALIST PRACTICE AND ASSOCIATES

Page: 01/01

PCNS Number : 016 000 1111111 Address : ROOM 10 WIERDA HOSPITAL
 VAT Number : 1234567/8 : 777 TOWN STREET
 Telephone : + 27 012 6531122 : WIERDA PARK 0149

MR GEORGE GREEN 10 TOWNHOUSE COMPLEX 155 CHURCH STREET WIERDA PARK CENTURION 0149	Account Number : GREEN001 Date Created : 20080601 Medical Scheme Name: ABC MEDICAL SCHEME Option / Plan Reference : OPT001 Membership Number : 0123456789 Member ID Number : 500101 0101 01 1 Member VAT Number : Telephone : +27 012 6532211 Elec. Response Required : N
--	---

Section 1.1

Claim Number : 100000001255
 Values are VAT inclusive @ 14% and are claimed in South African Rand

Claim Totals	Collection	VAT	Gross	Discount	Claimed
99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99

Patient Name : ANNIE ANDERSON, AA
 Patient Identification : ID No.: 4801010109089 Code: 01 Date of Birth: 19480101 Gender: F
 Treating / Attending Provider : DR SIMON SPECIALISTO Referring Provider : DR GERARD GENERAL
 PCNS Number : 016 000 2222222 PCNS Number : 014 000 8888888
 HPCSA Council Number : MP111111 HPCSA Council Number : MR222222

Section 1.2

Ref. Provider Diagnosis : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99

Item Service Date	Proc. code	Description	Qty	Patient	Gross	Discount	Claimed
001 20080601 08:00	0190	New & established pat	1	0.00	172.60	0.00	172.60
Diagnoses : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99							

Section 1.3

Referring Service Provider Diagnoses

Treating Service Provider Diagnoses

Example 2

Claim

KYE MEDICAL SPECIALIST PRACTICE AND ASSOCIATES

Page: 01/01

PCNS Number : 016 000 1111111
 VAT Number : 1234567/8
 Telephone : + 27 012 6531122

Address : ROOM 10 WIERDA HOSPITAL
 : 777 TOWN STREET
 : WIERDA PARK 0149

MR GEORGE GREEN
 10 TOWNHOUSE COMPLEX
 155 CHURCH STREET
 WIERDA PARK
 CENTURION
 0149

Account Number : GREEN001
 Date Created : 20080601
 Medical Scheme Name: ABC MEDICAL SCHEME
 Option / Plan Reference : OPT001
 Membership Number : 0123456789
 Member ID Number : 500101 0101 01 1
 Member VAT Number :
 Telephone : +27 012 6532211
 Elec. Response Required : N

Claim Number : 100000001255

Values are VAT inclusive @ 14% and are claimed in South African Rand

Claim Totals	Collection	VAT	Gross	Discount	Claimed
	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99

Patient Name : ANNIE ANDERSON, AA
 Patient Identification : ID No.: 4801010109089 Code: 01 Date of Birth: 19480101 Gender: F
 Treating / Attending Provider : DR SIMON SPECIALISTO Referring Provider : DR GERARD GENERAL
 PCNS Number : 016 000 2222222 PCNS Number : 014 000 8888888
 HPCSA Council Number : MF111111 HPCSA Council Number : MF22222
 Ref. Provider Diagnosis : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99

Item Service Date	Proc.code	Description	Qty	Patient	Gross	Discount	Claimed
001 20080601 08:00	0190	New & established pat	1	0.00	172.60	0.00	172.60
Diagnoses : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99							
Treating / Attending Provider : DR PETER PHYSICIAN				Referring Provider : DR SIMON SPECIALISTO			
PCNS Number : 016 000 3333333				PCNS Number : 016 000 2222222			
HPCSA Council Number : MF33333				HPCSA Council Number : MF111111			
Ref. Provider Diagnosis : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99							

Item Service Date	Proc.code	Description	Qty	Patient	Gross	Discount	Claimed
001 20080610 08:00	0190	New & established pat	1	0.00	172.60	0.00	172.60
Diagnoses : A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99 / A99.99							

Section 1.1

Section 1.2

Section 1.3

Section 1.2

Section 1.3

Diagnosis Standards

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** 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)

DSN01 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

- 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 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.

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 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.

B20.7 HIV disease resulting in multiple infections

- Sequence the individual HIV code in the primary position.

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

- 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 sarcoma

PDX: B21.0 HIV disease resulting in Kaposi sarcoma

SDX: C46.9 Kaposi sarcoma, unspecified

SDX: M9140/3 Kaposi sarcoma, malignant, primary site (C46.–)

Coding guideline – Kaposi Sarcoma

- The Physician must indicate a clear link between the HIV and Kaposi sarcoma.
- Coders must not assume that the Kaposi 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 2⁵

Please note that the Instruction Manual indicates that B22.7 should be assigned 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 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 sarcoma

SDX: C46.9 Kaposi sarcoma, unspecified

SDX: M9140/3 Kaposi sarcoma, malignant, primary site (C46.–)

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 Generalised enlarged lymph nodes

SDX: R21 Rash and other nonspecific skin eruption

⁵ Refer to 4.4.4 Chapter specific notes in the WHO, ICD-10 Instruction Manual (Volume 2)

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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:

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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:

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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

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

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: 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)

Example 2:

Patient admitted with primary multidrug resistant tuberculosis of the lung confirmed by culture.

PDX: A15.1 Tuberculosis of lung, confirmed by culture only

U50.00 Primary multidrug resistant tuberculosis (MDR TB)

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)

DSN0105 Coding diarrhoea and gastroenteritis without further specification

If the medical record indicates that the patient had both, gastroenteritis and vomiting then **A09.9**

Gastroenteritis and colitis of unspecified origin should be assigned.

- *Gastroenteritis typically involves both diarrhoea and vomiting*

If the medical record indicates that the patient had both diarrhoea and vomiting, then **A09.9 Gastroenteritis and colitis of unspecified origin** and **R11 Nausea and vomiting** should be assigned.

The reason for this is to keep the record of the vomiting until the cause of the diarrhoea has been established.

A code for dehydration must be assigned if documented. A code for dehydration should not be assigned if rehydration is documented without the mention of dehydration.

DSN0106 Coding of Retroviral Disease (RVD)

RVD without further specification will be assigned to **B33.3 Retrovirus infections, not elsewhere classified**.

If stated as the cause of disease then **B97.3 Retrovirus as the cause of diseases classified to other chapters** will be assigned as an additional code to the disease code.

DSN02 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.

Cancer⁶

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

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:

⁶ Refer to the note below Cancer in the WHO, ICD-10 Alphabetical Index (Volume 3)
The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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
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.⁷

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.

⁷ Refer to the note below morphology of neoplasms in the WHO ICD-10 Tabular List (Volume 1)
The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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, malignant, primary site

Secondary Malignancy

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

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

Rule:

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

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

Example:

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

PDX: C78.0 Secondary malignant neoplasm of lung
M8000/6 Neoplasm, malignant, metastatic site
SDX: C50.9 Malignant neoplasm, breast, unspecified
M8000/3 Neoplasm, malignant, primary site

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Note:

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

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 C79.9 Secondary malignant neoplasm, unspecified site should be 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 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

M8000/3 Neoplasm, malignant, primary site

SDX: C79.9 Secondary malignant neoplasm, unspecified site

M8000/6 Neoplasm, malignant, metastatic site

Example 2:

Metastatic cancer of the pleura

PDX: C80.9 Malignant neoplasm, primary site unspecified

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 C79.9 Secondary malignant neoplasm, unspecified site should be assigned.

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: C79.9 Secondary malignant neoplasm, unspecified site
M8010/6 Carcinoma, NOS, malignant, metastatic site
SDX: C80.9 Malignant neoplasm, primary site unspecified
M8010/3 Carcinoma, NOS, malignant, primary site

Common Sites of Metastases⁸

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 C80.9 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
- Lymph nodes
- Mediastinum
- Meninges
- Peritoneum
- Pleura
- Retroperitoneum
- Spinal Cord
- Ill-defined sites (sites classifiable to C76.–)

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: C80.9 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 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 sarcoma of the skin as a result of HIV

PDX: B21.0 HIV disease resulting in Kaposi sarcoma
SDX: C46.0 Kaposi sarcoma of skin
M9140/3 Kaposi sarcoma, malignant, primary site (C46.–)

⁸ WHO, ICD-10 Instruction Manual (Volume 2)

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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 lung

PDX: C80.9 Malignant neoplasm, primary site unspecified

M8010/3 Carcinoma, NOS, malignant, primary site

SDX: C78.0 Secondary malignant neoplasm of lung

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

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

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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

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

Example:

Recurrent malignant neoplasm of posterior wall of bladder

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

M8000/3 Neoplasm, malignant, primary site

History of Neoplasm

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

“History of neoplasm”

Code as such if:

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

Example:

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

PDX: C79.6 Secondary malignant neoplasm of ovary

M8000/6 Neoplasm, malignant, metastatic site

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

Standard

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

Example:

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

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

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

Follow-up Examinations

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

Example:

Colonoscopy for adenocarcinoma of colon with no recurrence found.

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

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

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

Guideline

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

Remission in leukemia and other malignant lymphoid and haematopoietic neoplasms

Standard

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

PDX: Z85.6 Personal history of leukaemia

SDX: Z51.1 Chemotherapy session for neoplasm

Or

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

SDX: Z51.1 Chemotherapy session for neoplasm

Coding of radiotherapy and chemotherapy treatment for neoplasms

Radiotherapy

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

Chemotherapy

The treatment of diseases by chemical agents.

Standard

Z51.0 Radiotherapy session

This code should be assigned in the secondary position.

Z51.1 Chemotherapy session for neoplasm

This code should be assigned in the secondary position.

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

Example 1:

Patient admitted for chemotherapy following oophorectomy for malignant teratoma.

PDX: C56 Malignant neoplasm of ovary

M9080/3 Teratoma, NOS, malignant, primary site

SDX: Z51.1 Chemotherapy session for neoplasm

Example 2:

Patient is admitted one day post chemotherapy with dehydration, nausea and vomiting.

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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

Guideline

Z51.2 Other chemotherapy should be assigned when chemotherapy is administered for treatment of non-cancer diagnoses e.g. for the treatment of auto-immune conditions.

Chemotherapy can also refer to highly complex drugs, highly complex biologic agents and anti-neoplastic agents.

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

DSN0202 Coding of Gastrointestinal Stromal Tumours

Establish if the neoplasm is malignant (primary or secondary), in situ, benign or of uncertain behavior or unspecified nature and assign the appropriate ICD-10 code.

Neoplasm	Primary	Secondary	In situ	Benign	Uncertain / Unknown behaviour
Gastrointestinal (tract) NEC	C26.9	C78.8	D01.9	D13.9	D37.9

Assign the appropriate morphology code for the gastrointestinal stromal tumour.

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

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: N18.9+ Chronic kidney disease, unspecified

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

DSN0302 Coding Haemophilia with Epistaxis

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

Example:

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

PDX: D66 Hereditary factor VIII deficiency

SDX: R04.0 Epistaxis

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 condition⁹.

⁹ WHO, ICD-10 Tabular List (Volume 1), refer to point (f) below chapter XVIII

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

DSN0401 Type 2 diabetic who requires insulin

There is currently no appropriate ICD-10 code for a type 2, diabetic patient who occasionally requires insulin therapy. E11 Type 2 diabetes mellitus should be 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 form¹⁰. Medical practitioner service modifier 0018 is used as an obesity indicator for medical practitioners.

The WHO classification of "overweight" and "obesity" is as follows:
Overweight (grade 1 obesity) is defined as a BMI of 25 – 29.9kg/m²
Obesity (grade 2) as BMI 30 – 39.9 kg/m²
Morbid Obesity (grade 3) as BMI > 40kg/m²

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

In practice abnormal and excessive fat distribution can also be measured by the waist hip ratio (WHR) with abnormal WHR being > 0.90 in men and > 0.85 in women¹¹.

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

¹¹ Extracted from NCCH ICD-10-AM, July 2002, Endocrine, Nutritional and Metabolic Diseases and the Australian Coding Standards, Third Edition, ICD-10 AM
The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

DSN05 Mental and behavioural disorders (F00 – F99)

DSN0501 Mental and behavioural disorders due to alcohol, drug and tobacco use

Mental and behavioural disorders due to psychoactive substance use (F10-F19)

When the use of psychoactive substance is documented **as abuse, dependence, use disorder, intoxication or harmful use**, a code should be assigned from this category with the use of the appropriate 4th character to specify the clinical state.

Guideline

Z72.0 Tobacco use

This code is to be assigned for current smokers.

Z72.1 Alcohol use

This code may be assigned to indicate alcohol use even when mentioned as “patient drinks occasionally”.

Z72.2 Drug use

This code may be assigned to indicate drug use.

Z86.4 Personal history of psychoactive substance abuse

This code is to be used when the patient is not a current user of a psychoactive substance but has been a user **at anytime in their life**.

Example 1:

Patient admitted with alcohol-related pancreatitis.

PDX: K86.0 Alcohol-induced chronic pancreatitis (if chronic) **or** K85.2 Alcohol-induced acute pancreatitis (if acute)

SDX: F10.– to indicate harmful use or dependence etc.

** There should be clear documentation by the medical practitioner indicating acute or chronic*

Example 2:

Patient admitted with chronic alcohol-related pancreatitis. According to the records, he has in the past been admitted twice for alcohol rehabilitation.

PDX: K86.0 Alcohol-induced chronic pancreatitis

SDX: F10.– to indicate harmful use or dependence etc.

SDX: Z92.5 Personal history of rehabilitation measures

Example 3:

75 year old patient admitted with smoking related chronic obstructive pulmonary disease (COPD). Notes indicate that he has been unsuccessful in his attempts to quit.

PDX: J44.9 Chronic obstructive pulmonary disease, unspecified

SDX: F17.1 Mental and behavioural disorders due to use of tobacco, harmful use

Example 4:

Records indicate that the patient has depression, anxiety and physical violent tendencies due to the use of "ice / tik". Parents have requested admission to the rehabilitation facility. Patient will be transferred from the acute unit to the rehabilitation facility. This is a repeat admission to the acute facility.

PDX: F32.9 Depressive episode, unspecified

SDX: F41.9 Anxiety disorder, unspecified

SDX: R45.6 Physical violence

SDX: F15.1 Mental and behavioural disorders due to use of other stimulants including caffeine, harmful use

Example 5:

A 16 year old patient admitted with alcohol intoxication.

PDX: F10.0 Mental and behavioural disorders due to use of alcohol, acute intoxication

DSN09 Diseases of the circulatory system (I00 – I99)

DSN0901 Coding of the Circulatory System

Rheumatic and Nonrheumatic Valve Disorders

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

High arterial blood pressure

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

Hypertensive¹²:

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

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

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 1:

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 2:

¹² Dorland's Medical Dictionary, 29th Edition

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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

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

SDX: 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

PDX: 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 1:

Hypertensive end stage renal failure

PDX: I12.0 Hypertensive renal disease with renal failure

SDX: N18.5 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 kidney disease, unspecified

SDX: I50.0 Congestive heart failure

I15 Secondary hypertension

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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 kidney disease, unspecified

Ischaemic Heart Diseases (I20 – I25)

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 acute or with a stated duration of 4 weeks (28 days) or less from onset.
- Whether it is subsequent (recurrent with a stated duration of 4 weeks (28 days) or less from onset)
- Whether it is chronic or with a stated duration of more than 4 weeks (more than 28 days from onset)
- Whether it is an old MI or a healed MI

Acute myocardial infarctions are classified to categories I21 – I22.

Categories I21 – I22 includes any myocardial infarction with a stated duration of **FOUR** weeks or less.

The time reference of four weeks must be observed for uniformity in reporting. The four weeks refers to the interval elapsing between the onset of the ischaemic episode and admission to care.

I21 Acute myocardial infarction

I21. – Classifies an acute myocardial infarction.

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** should be assigned.
- If not chronic, it will be a subsequent MI and a code 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 differs, from the previous MI.

Definitions

Transmural Infarction

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

Ischemic necrosis of the full thickness of the affected muscle segment(s), extending from the endocardium through the myocardium to the epicardium.

Nontransmural

A nontransmural MI is defined as an area of ischemic necrosis that does not extend through the full thickness of myocardial wall segment(s). In a nontransmural MI, the area of ischemic necrosis is limited to the endocardium or to the endocardium and myocardium.

Subendocardial infarct

Occurs in the subendocardial muscle even when the epicardial portions of the muscle remain uninfarcted.

Guidelines

Example 1:

Acute anterior wall myocardial infarction. First episode.

PDX: I21.0 Acute transmural myocardial infarction of anterior wall

Example 2:

Acute anterior wall myocardial infarction and lateral wall in the same first episode.

PDX: I21.0 Acute transmural myocardial infarction of anterior wall

SDX: I21.2 Acute transmural myocardial infarction of other sites

Should a patient who is in hospital due to an AMI have a subsequent AMI while still in the hospital within the 4 weeks of the initial MI, the definition of the PDX will apply in terms of sequencing.

Example 3:

Acute anterior wall myocardial infarction. First episode. While in hospital, the patient develops a new myocardial infarction – inferior wall, within the 4 weeks of the initial myocardial infarction.

PDX: I22.1 Subsequent myocardial infarction of inferior wall

SDX: I21.0 Acute transmural myocardial infarction of anterior wall

Or

PDX: I21.0 Acute transmural myocardial infarction of anterior wall

SDX: I22.1 Subsequent myocardial infarction of inferior wall

Example 4:

Acute anterior wall myocardial infarction. First episode. After discharge, the patient develops a new myocardial infarction – inferior wall within the 4 weeks of the initial myocardial infarction.

PDX: I22.1 Subsequent myocardial infarction of inferior wall

Example 5:

Acute anterior wall myocardial infarction. Previous infarction 4 months ago.

PDX: I22.0 Subsequent myocardial infarction of anterior wall

Example 6:

Chronic myocardial infarction, anterior wall

PDX: I25.8 Other forms of chronic ischaemic heart disease

Example 7:

Nontransmural myocardial infarction

PDX: I21.4 Acute subendocardial myocardial infarction

Example 8:

Acute Myocardial infarction

PDX: I21.9 Acute myocardial infarction, unspecified

Example 9:

Recurrent myocardial infarction

PDX: I22.9 Subsequent myocardial infarction of unspecified site

Example 10:

Subsequent myocardial infarction of the anterior wall and inferior wall in the same episode.

PDX: I22.0 Subsequent myocardial infarction of anterior wall

SDX: I22.1 Subsequent myocardial infarction of inferior wall

Example 11:

Subsequent myocardial infarction of the inferior wall following an old myocardial infarction.

PDX: I22.1 Subsequent myocardial infarction of inferior wall

SDX: I25.2 Old myocardial infarction

Example 12:

Patient admitted to hospital A with an acute anterior wall myocardial infarction and subsequently transferred to hospital B.

Hospital A

PDX: I21.0 Acute transmural myocardial infarction of anterior wall

Hospital B

PDX: I21.0 Acute transmural myocardial infarction of anterior wall

Example 13:

Atherosclerosis of a bypass graft (not a native artery) should be coded in the following way.

PDX: I25.1 Atherosclerotic heart disease

SDX: Z95.1 Presence of aortocoronary bypass graft

Or

PDX: I25.1 Atherosclerotic heart disease

SDX: Z95.5 Presence of coronary angioplasty implant and graft

The terms '**recurrent**' and '**subsequent**' are utilised interchangeably or synonymously.

I24 Other acute ischaemic heart diseases

Category I24 classifies other acute forms of ischaemic heart disease, which for the most part represent precursor states of acute myocardial infarction.

An exception is the post myocardial infarction syndrome (Dressler's syndrome) I24.1.

Guidelines

- I25.2 Old myocardial infarction is essentially a “history code” even though it does not appear in chapter 21. 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.

DSN10 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.

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.–.

DSN1003 Avian Flu

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

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.–.

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.

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®).

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.

DSN1008 Coding of A/H1N1 [swine flu]

J09 Influenza due to certain identified influenza virus to be assigned for A/H1N1 [swine flu].

DSN11 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 **GSN0013 Coding of Syndromes**.

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

DSN1201 Cosmetic surgery for skin laxity following weight loss

Assign the following ICD-10 codes for cosmetic surgery for skin laxity following weight loss

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

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

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

DSN1301 Necrotizing Fasciitis – removed

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.

DSN1303 Osteopaenia

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

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.

DSN1305 Site of musculoskeletal involvement

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, bilateral

Refer to the excludes note under M15 Polyarthrosis

Excludes: bilateral involvement of a single joint (M16 – M19)

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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, cervicgia and pain in upper limbs if these represent important problems in the medical care rendered.

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 kidney disease, unspecified

SDX: Z49.1 Extracorporeal dialysis

DSN15 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 twenty-second (22nd) week of gestation.

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. 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: O60.3 Preterm delivery without spontaneous labour

SDX: O80.9 Single spontaneous delivery, unspecified

SDX: Z37.0 Single live birth

O00 Ectopic Pregnancy

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

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.

O03 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.

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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

O05 Other abortion

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

O06 Unspecified abortion

O06.– can be assigned for an unspecified abortion where an abortion occurred and no further information is available.

Unspecified abortion also 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.

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: K35.8 Acute appendicitis, other and unspecified
SDX: O03.9 Spontaneous abortion, complete or unspecified, without complication

O07 Failed attempted abortion

Failed attempted abortion is the failure or attempted induction of abortion – legal or illegal. The attempted abortion is unsuccessful and the foetus survives.

Partly removed foetus following an abortion

Example:

A patient is admitted for an abortion

PDX: O06.9: Unspecified abortion, complete or unspecified, without complication

The code for “failed attempted abortion” should be used if the method of termination does not result in terminating the pregnancy and there is still a viable fetus within the uterus.

Coding for subsequent admission:

PDX: O07.8: Other and unspecified failed attempted abortion, with other and unspecified complications

Coding of Pregnancy with abortive outcome (O00 – O08)

Episode as described in categories O00 – O08

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 – O02)

Use an additional code from category O08 Complication following abortion and ectopic and molar pregnancy to indicate any associated complications for categories O00 – O02.

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: O04.8 Medical abortion, complete or unspecified, with other and unspecified complications

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

Abortifacient drugs

An abortifacient is any drug or chemical preparation that induces abortion e.g. mifepristone.

Example 1:

Patient admitted for “missed abortion”. Given Mifepristone tabs and sent home before the foetus is aborted.

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PDX: O02.1 Missed abortion

Example 2:

Patient is admitted with an intra-uterine death (IUD). Given Mefipristone tabs and sent home before the foetus is aborted.

PDX: O36.4 Maternal care for intrauterine death

Interception of pregnancy

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

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 (O14.2)

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 (O14.2) must be assigned if the patient presents with both conditions.

Coding of HELLP syndrome which resulted in a ruptured liver

Sequence O14.2 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.

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.

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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.

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

SDX: E10.1 Type 1 diabetes mellitus with ketoacidosis

Maternal care for other conditions predominantly related to pregnancy

O26.8 Other specified pregnancy-related conditions

This code should be used to record conditions that are solely pregnancy induced that do not have separate subterms for “complicating pregnancy” in the alphabetical index.

Example 1:

Patient treated for backache related to pregnancy.

PDX: O26.8 Other specified pregnancy-related conditions

SDX: M54.99 Dorsalgia, unspecified, site unspecified

Example 2:

Patient treated for pregnancy related abdominal pain.

PDX: O26.8 Other specified pregnancy-related conditions

SDX: R10.4 Other and unspecified abdominal pain.

Maternal care for other conditions not predominantly related to pregnancy

Assign a code for the condition which is not pregnancy related with an additional code Z33 Pregnant state, incidental to indicate that the patient is pregnant.

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Assign Z34.– Supervision of normal pregnancy or Z35.– Supervision of high-risk pregnancy if the pregnancy was monitored during the episode of care.

Example 1:

Patient admitted for treatment of a radial fracture. She slipped and fell at home. She is currently twenty-two weeks pregnant.

PDX: S52.80 Fracture of other parts of forearm, closed

SDX: W01.09 Fall on same level from slipping, tripping and stumbling, home, during unspecified activity

SDX: Z33 Pregnant state, incidental

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 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. A tocolytic 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

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 prolonged beyond the ordinary 18-hour limit.

1st stage of labour

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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

An elective caesarean section is done:

- because of a medical indication or an obstetrical indication before the onset of labour e.g. cephalopelvic disproportion, unstable lie.
- because of patient's choice.

An emergency caesarean section is done:

- because of a medical indication or an obstetrical indication before the onset of labour or during labour which potentially could result in harm to the mother or baby/foetus e.g. foetal distress which can present during the course of labour or before the onset of labour,
- to prevent any delay in delivery which could result in permanent injury/harm or death to foetus or mother.

Emergency Caesarean Section

Assign **O82.1 Delivery by emergency caesarean section** in addition to **O84.2 multiple delivery, all by caesarean section** to indicate that the caesarean section was an emergency.

Sequence the code for the reason for the caesarean section first.

Example:

Patient had an emergency caesarean section for foetal distress. Live born twins delivered by an emergency caesarean section.

PDX: O36.3 Maternal care for signs of fetal hypoxia

SDX: O30.0 Twin pregnancy

SDX: O84.2 Multiple delivery, all by caesarean section

SDX: O82.1 Delivery by emergency caesarean section

SDX: Z37.2 Twins, both liveborn

Coding of a delivery with premature rupture of membranes with chorioamnionitis

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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

Z37 Outcome of Delivery

This category is intended for use as an additional code to identify the outcome of delivery on the mother's record.

Z37.– should appear once on the mother's record. This code should be assigned by the hospital or the organisation that has managed the actual delivery.

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: O98.7 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: O98.7 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: O98.7 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: O98.7 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

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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: O98.7 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 sarcoma

SDX: C46.0 Kaposi sarcoma of skin

SDX: M9140/3 Kaposi 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: O98.7 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: O98.7 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

Coding of Neoplasms and Deliveries

Example:

Malignant Neoplasm of the vagina complicating pregnancy, resulting in an elective c-section. A live born infant is delivered

PDX: O99.8 Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium

SDX: O82.0 Delivery by elective caesarean section

SDX: Z37.0 Single live birth

SDX: C52 Malignant neoplasm of vagina

M8000/3 Neoplasm, malignant, primary site

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.

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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

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.

DSN1505 Other Obstetric Conditions

O98 Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium and O99 Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium

Categories O98.– and O99.– include the listed conditions when complicating the pregnant state, when aggravated by the pregnancy or as a reason for obstetric care and for which the Alphabetical Index does not indicate a specific rubric in Chapter XV.

The pertinent codes from other chapters are used as additional codes to allow specification of the condition.

Exceptions to the rule:

- A34 Obstetrical tetanus
- F53 Mental and behavioural disorders associated with the puerperium, not elsewhere classified
- M83.0 Puerperal osteomalacia
- S00 – T98 Injury, poisoning and certain other consequences of external causes

Example 1:

28/52 pregnant with lobar pneumonia.

PDX: O99.5 Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium

SDX: J18.1 Lobar pneumonia, unspecified

Exception to the rule:

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

Example 2:

28/52 pregnant. Fell down the stairs at home. Fracture ankle, closed.

PDX: S82.80 Fracture of other parts of lower leg, closed

SDX: W10.09 Fall on and from stairs and steps, Home, During unspecified activity

SDX: Z33 Pregnant state, incidental

DSN16 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

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 birth¹³.

Neonatal period

The neonatal period commences at birth and ends 28 completed days after birth.

Note:

Refer to **DSN2138** for the use of Z38 Liveborn infants according to place of birth.

Chapter XVI (Certain conditions originating in the perinatal period) includes conditions that have their origin in the perinatal period (and neonatal period) even though death or morbidity occurs later

P codes may also be assigned as the primary diagnosis after the perinatal or neonatal period has ended.

Example 1:

16 year old admitted for bronchopulmonary dysplasia due to hyaline membrane disease at birth.

PDX: P27.1 Bronchopulmonary dysplasia originating in the perinatal period

Example 2:

Newborn admitted with patent ductus arteriosus. Known to have Down's Syndrome. Developed hospital acquired Klebsiella pneumonia in the second week.

PDX: Q25.0 Patent ductus arteriosus
SDX: J15.0 Pneumonia due to Klebsiella pneumonia
SDX: Y95 Nosocomial condition
SDX: Q90.9 Down's syndrome, unspecified
SDX: Z38.0 Singleton, born in hospital

Example 3:

Newborn admitted for upper respiratory infection.
PDX: P28.8 Other specified respiratory conditions of newborn
SDX: J06.9 Acute upper respiratory infection, unspecified

¹³ Certain conditions in the neonatal period will be coded to Chapter XVI of the WHO, ICD-10 Tabular List (Volume 1) The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

DSN1603 Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00 – P04)

- These codes are only assigned if the fetus and newborn are affected by maternal factors or by complications of pregnancy, labour and delivery
- The actual morbid condition is assigned as the primary diagnosis / main condition.
- The codes (P00 – P04) are assigned as additional codes.
- P00 – P04 can be used as the main condition / primary diagnosis if it was a stillborn infant for mortality purposes.

Example 1:

Cord around the neck with severe birth asphyxia. Baby born in hospital.

PDX: P21.0 Severe birth asphyxia

SDX: P02.5 Fetus and newborn affected by other compression of umbilical cord

SDX: Z38.0 Singleton, born in hospital

Example 2:

Newborn, born in hospital, developed ophthalmitis due to maternal gonococcal infection

PDX: A54.3+ Gonococcal infection of eye

SDX: H13.1* Conjunctivitis in infectious and parasitic diseases classified elsewhere

SDX: P00.2 Fetus and newborn affected by maternal infectious and parasitic diseases

SDX: Z38.0 Singleton, born in hospital

DSN1604 Disorders related to short gestation and low birth weight, not elsewhere classified (P07)

When both birth weight and gestational age are available, priority of assignment should be given to birth weight.

Example:

Baby born in hospital at 28/52 with a birth weight of 900g.

PDX: P07.0 Extremely low birth weight

SDX: P07.3 Other preterm infants

SDX: Z38.0 Singleton, born in hospital

DSN1605 Fetal death of unspecified cause (P95)

Whenever possible, fetal deaths should be classified according to the cause of death.

P95 should only be used if the cause of death is unknown.

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

'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

Example 3:

Known diabetic admitted for hyperglycaemia

PDX: E10.– to E14.– Diabetes mellitus

SDX: R73.9 Hyperglycaemia, unspecified

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. The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

considered (or that the patient appeared to be recovering so further investigations were not being undertaken but that there was a significant level of uncertainty over the actual diagnosis).

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

DSN1801 Coding a Death

R99 other ill-defined and unspecified causes of mortality

The use of R99 other ill-defined and unspecified causes of mortality is not mandatory.

An ICD-10 code can be used to indicate death until the disposal or discharge disposition codes have been agreed on for the South African environment. If the cause of death is unknown R99 other ill-defined and unspecified causes of mortality can be used.

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 disease¹⁴.

Example 1:

Patient admitted with pancreatitis and developed SIRS.

PDX: K85.9 Acute pancreatitis, unspecified

SDX: R65.9 Systemic Inflammatory Response Syndrome, unspecified

¹⁴ Reference: WHO ICD-10, Volume 1

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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

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

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

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

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.

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

SDX: Y57.9 Drug or medicament, unspecified

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.

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 injuries¹⁵

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

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

¹⁵ WHO, ICD-10 Instruction Manual (Volume 2)

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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.

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.

Open and Closed Injuries¹⁶

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 without open wound.¹⁷

Refer to **GSN0006 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. 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.

¹⁶Refer 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)

¹⁷ Reference: WHO ICD-10, Volume 2

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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.

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

Coding of a fractured penis

Example:

Patient sustained a fractured penis

PDX: S39.8 Other specified injuries of abdomen, lower back and pelvis
SDX: External cause code

DSN1906 Complications of Surgery and Medical Care

Definition

A complication may arise subsequently to an existing condition, disease, pregnancy, injury, etc. or subsequent to treatment, procedures, adverse reaction to drugs and / or chemicals, grafts, prosthetics or and/ or devices or as a direct consequence of the hospitalization, etc.

Existing condition

Example:

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

PDX: E11.5 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*

A complication may become a principal diagnosis despite it not being the cause of admission **if it becomes the main condition treated or it complies with the definition of the principal diagnosis.**

Certain conditions / complications are expected as part of the surgical pathophysiology. These are classified to the body system chapters and do not require external cause codes.

Example:

Intracranial hypotension following ventricular shunting

PDX: G97.2 Intracranial hypotension following ventricular shunting

Post-procedural Disorders / Condition

Certain conditions resulting from medical or surgical care are residual conditions of a procedure, but no complicating factor is involved.

It is a condition or injury which is related to a surgical / procedural intervention rather than being related to the patient's disease process.

These conditions are classified to the body system chapters.

These conditions can become the principal diagnosis if they become the main condition that is being treated.

Example:

Intracranial hypotension following ventricular shunting

PDX: G97.2

NB: No external cause code is required

There are common symptoms during post-operative recovery e.g. pain, vomiting etc, which are not coded as complications, unless the clinician / service provider identifies them specifically as complications of the surgery

Complications due to presence of internal device, implant or graft

Complications of this type are classified first according to whether they are mechanical or non-mechanical in nature.

A mechanical complication is one that results from failure of the device, implant or graft, such as displacement, malfunction or breakage.

- T82 Complications of cardiac and vascular prosthetic devices, implants and grafts
- T83 Complications of genitourinary prosthetic devices, implants and grafts

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- T84 Complications of internal orthopaedic prosthetic devices, implants and grafts
- T85 Complications of other internal prosthetic devices, implants and grafts

Malfunction

Malfunction is when something functions wrongly or does not function at all, this includes complications due to the presence of an internal device, an implant or a graft. This can be mechanical or non-mechanical.

Example 1:

Mechanical complication of the battery of pacemaker

PDX: T82.1 Mechanical complication of cardiac electronic device

SDX: ECC

Example 2:

Replacement of a permanent pace maker (flat battery)

PDX: Z45.0 Adjustment and management of cardiac pacemaker.

Misadventure

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

Misadventures to patients during surgical and medical care (Y60 – Y69)

This category indicates that the misadventure was due to human intervention

Example:

Accidental puncture of uterus during a dilation and curettage (D&C)

PDX: T81.2 Accidental puncture and laceration during a procedure, not elsewhere classified

SDX: Y60.0 Unintentional cut, puncture, perforation or haemorrhage during surgical and medical care, during surgical operation.

Medical devices associated with adverse incidents in diagnostic and therapeutic use (Y70 – Y82)

These codes are used when the misadventure or adverse event was **not** due to any action of the clinician but due to failure or malfunction of a device.

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 (Y83 – Y84)

Breakdown or malfunction of the device is coded to Y70-Y82.

T79 Certain early complications of trauma, not elsewhere classified

The coder should remember that the “not elsewhere classified” is effectively a warning that the conditions described may be more specifically classified elsewhere.

Early Complication of a procedure

One that occurs in the immediate post / peri-operative period i.e. while the patient is in the operating room / intervention room or during the postoperative monitoring period of 96 hours that is counted from the time the patient leaves the operating room / intervention room. An external cause code must be assigned. In this case there is a definite cause-effect relationship between the surgery performed and the specified complication.

Late Complication of a procedure

One that occurs after 96 completed hours following the patient's departure from the operating room / intervention room subsequent to any surgical procedure. The complication must be specified as “postprocedural” or “postoperative” on the patient's record. An external cause code must be assigned. In this case there is a definite documented relationship between the surgery performed and the specified complication. This might also present as a readmission after the patient has been discharged.

Transient complications

This are common symptoms during post-operative recovery e.g. pain, vomiting etc, which are not coded as complications, unless the clinician / service provider identifies them specifically as complications of the surgery.

Functional Complication

This is a disturbance of normofunction of a body system. Example – arrhythmia is a functional heart disturbance and malabsorption is a functional gastrointestinal disturbance. The word “functional” is sometimes printed in brackets because it is treated as a nonessential modifier according to ICD-10 coding conventions.

Whenever a complication of a procedure is not indexed or is not a synonym of an inclusion or indexed term, proceed as follows¹⁸:

Code to T80 – T88:

- early complications of medical procedure;
- mechanical complications;

Code to appropriate system chapter:

- late complications;
- functional complications;

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.
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” (**DSN1905 Coding Injuries**).

¹⁸ Refer to notes below the lead term “Complications” in the WHO, ICD-10 Alphabetical Index (Volume 3) The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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

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.

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.

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."

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."

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.

Guideline for External Cause Codes Y40 – Y84

The above range of ICD-10 codes is 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 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) 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.”

Y48.– Anaesthetic and therapeutic gases

These codes are being used incorrectly to indicate that some form of anaesthetic was administered. These codes indicate “drugs, medicaments and biological substances causing adverse effects in therapeutic use”.

Y84.0

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

The full descriptions of all these complication codes are included on the ICD-10 Master Industry Table (MIT).

Place of Occurrence “5 Trade and Service area”

A fourth character code “5” indicating “Trade and service area” can be assigned for the following:

- Shebeen
- Pub
- Tavern

Definitions related to transport accidents

Public Roads will include:

- Municipal Road
- National Road
- Provincial Road

An external cause code should be assigned when assigning one of the following codes

- Z04.1 Examination and observation following transport accident
- Z04.2 Examination and observation following work accident
- Z04.3 Examination and observation following other accident
- Z04.4 Examination and observation following alleged rape and seduction
- Z04.5 Examination and observation following other inflicted injury

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 travelling 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 travelling from work to a client or a health practitioner travelling 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.

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

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travelling home from work. The 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 travelling 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.**"

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. 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 **DSN2135 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 **DSN2135 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 **DSN2135 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.

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 be¹⁹.

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.
-

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.

DSN2106 Emergency Radiology – removed

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.

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.

¹⁹ Reference – Medical Practitioners Guide to Fees 2005

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.

DSN2110 Repair of a Denture

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

DSN2111 Frames sold without lenses being fitted

Code Z46.0 Fitting and adjustment of spectacles and contact lenses is the appropriate code for use when frames are sold without lenses being fitted.

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

DSN2113 Repeat prescription for spectacles

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

DSN2114 Binocular Vision Therapy

Z50.6 Orthoptic training includes binocular vision therapy.

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**

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

DSN2117 Sports Mouth Guard – removed

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

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.

DSN2120 Antenatal Classes

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

DSN2121 Finding and a Routine X-ray – removed

DSN2122 After hours radiological investigations – removed

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 prosthesis²⁰.

²⁰ Definition of a Post – Dr Neil Campbell

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

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

DSN2124 Z – codes Invalid in the Primary Position

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

DSN2125 Issues of Consent – removed

DSN2126 Repair of a Hearing Device

The condition requiring the hearing aid should be 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

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

DSN2128 Coding for Microbiology – removed

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 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)

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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 an 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 3:

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

PDX: Z29.8 Other specified prophylactic measures

Example 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 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

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**.

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

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**

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 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.

- Z85 Personal history of malignant neoplasm
- Z86 Personal history of certain other diseases
- Z87 Personal history of other diseases and conditions
- Z88 Personal history of allergy to drugs, medicaments and biological substances

Family History

Family History codes often are used to indicate the need for prophylactic surgery and treatment. Family history codes are used with screening codes to justify the test or procedure.

- Z80 Family history of malignant neoplasm
- Z81 Family history of mental and behavioural disorders
- Z82 Family history of certain disabilities and chronic diseases leading to disablement
- Z83 Family history of other specific disorders
- Z84 Family history of other conditions

These codes (**personal history and family history codes**) are very rarely used alone or as the main condition treated.

Example 1:

Patient has a personal history of Asthma. Had asthma as a child. No evidence of current treatment/management for this condition.

Admitted for depression.

PDX: F32.9 Depressive episode, unspecified

SDX: Z87.0 Personal history of diseases of the respiratory system

Example 2:

Clinical notes:

Hx

- Known diabetic (IDDM)
- Known H/T

If the condition/s are current, meaning that the patient is receiving treatment or is being managed for the condition/s, then code as current.

Example 3:

Patient presents with dysphagia with a history of a CVA six months ago.

Look at the context in which this term “history” is used. If the CVA is current code as:

PDX: R13 Dysphagia

SDX: I64 Stroke, not specified as haemorrhage or infarction

If the CVA is **no longer present / current** but is the cause of the dysphagia, or the dysphagia is a residual of the CVA, code as a “sequelae”. Refer to **GSN0015 Sequelae (Late Effects)**.

PDX: R13 Dysphagia

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

Example 4:

Where there is no sequelae code, we can start to look for a history code should this information be important / affect the current admission into hospital.

Patient presents with dysphagia as a late effect of oesophageal cancer diagnosed and treated 5 years ago with no recurrence.

PDX: R13 Dysphagia

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

Example 5:

Patient has a history of an old myocardial infarction. See **DSN0901 Coding of the Circulatory System**.

PDX: I25.2 Old myocardial infarction

When certain information may be of importance e.g. history of a bypass graft or history of insertion of a pacemaker then the coder would not use a history code but rather a code indicating presence of a device.

Example 6:

Patient has a history of a cardiac pacemaker.

PDX: Z95.0 Presence of cardiac pacemaker

Example 7:

If a patient presents for a laparoscopy with a history of pv bleeding, then this should still be coded as the current condition as it is still being investigated.

PDX: N93.9 Abnormal uterine and vaginal bleeding, unspecified

DSN2135 Special Screening examination

Special Screening examination

Special screening examinations are done in patients who are at risk of developing a certain disease / condition, e.g. in a patient with a strong family history of breast cancer, routine special breast screening examinations will be done.

It is a test done without signs and symptoms of the disease/condition. (The disease is not pre-existing) These codes are **not** to be used when a patient has been diagnosed with the disease/condition.

This applies to the following codes:

- **Z11** Special screening examination for infectious and parasitic diseases
- **Z12** Special screening examination for neoplasms
- **Z13** Special screening examination for other diseases and disorders

Example 1:

26 Year old male for a HIV test

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

Example 2:

Patient admitted for a colonoscopy and a gastroscopy. Has a family history of gastro-intestinal cancer.

PDX: Z12.1 Special screening examination for neoplasm of intestinal tract

SDX: Z80.0 Family history of malignant neoplasm of digestive organs

When a sign and / or symptom is the reason for the examination, assign the appropriate code to the sign and / or symptom.

Example 3:

Patient admitted for a gastroscopy. Has a history of abdominal pain.

PDX: R10.4 Other and unspecified abdominal pain

Assign the appropriate code for the disease or the condition if established at the time of the screening.

Example 4:

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Patient admitted for a gastroscopy. Has a history of abdominal pain. Gastric ulcer found on examination.

PDX: K25.9 Gastric ulcer, unspecified as acute or chronic, without haemorrhage or perforation

Follow-up examinations with a history of a neoplasm or other conditions should be assigned to Z08.– Follow-up examination after treatment for malignant neoplasm or Z09.– Follow-up examination after treatment for conditions other than malignant neoplasms.

DSN2136 Surgery not performed

If the procedure has been cancelled due to the patient having an infection e.g. influenza then code as follows:

PDX: Reason for the surgery

SDX: Z53.0 Procedure not carried out because of contraindication

SDX: Reason for the cancellation – influenza

If the procedure has been cancelled due to the patient having an infection e.g. chest infection and the patient is treated for the infection then the condition treated must be sequenced as the primary diagnosis.

PDX: Reason for the cancellation – chest infection

SDX: Z53.0 Procedure not carried out because of contraindication

SDX: Reason for the surgery

DSN2137 Blood test for DNA

Example:

Patient brought in by the police for blood tests for DNA

PDX: Z04.8 Examination and observation for other specified reasons

DSN2138 Liveborn infants according to place of birth (Z38)

- A code from category Z38 Liveborn infants according to place of birth must be sequenced as the primary diagnosis for a healthy liveborn infant.
- An appropriate diagnosis code should be sequenced in the primary position should the baby require a healthcare intervention. A code from category Z38 Liveborn infants according to place of birth must be assigned as an additional code.
- A code from category Z38 Liveborn infants according to place of birth can only be used once when the baby is admitted following the delivery therefore Z38.– should not be assigned for any subsequent admissions or transfers to other hospitals.

The use of this category by paediatricians

Example 1:

Baby born in hospital. The paediatrician needs to bill for the routine examination of the baby.

PDX: Z00.1 Routine child health examination

SDX: Z38.0 Singleton, born in hospital

Z38.0 Singleton, born in hospital

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Hospital in the above description will therefore refer to any practices starting with the following practice type:

- 047 – Drug and Alcohol Rehabilitation
- 049 – Sub-Acute Facilities
- 055 – Mental Health Institutions
- 056 – Provincial Hospitals
- 057 – Private Hospitals (Status A)
- 058 – Private Hospitals (Status B)
- 059 – Private Rehabilitation Hospitals (Acute)
- 076 – Unattached Operating Theatres / Day Clinics
- 077 – Approved Unattached Operating Theatres / Day Clinics
- 079 – Hospices

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 **DSN1401 Coding of Dialysis** and **DSN2134 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.

Note:

The 5th character indicates whether drug resistance is primary or secondary as follows²¹:

0 indicates Primary resistance (transmission of a resistant strain, not previously diagnosed or treated)

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

U50 Drug resistant tuberculosis

U50.0 Multidrug resistant tuberculosis (MDR TB)

U50.00 Primary multidrug resistant tuberculosis (MDR TB)

U50.01 Secondary multidrug resistant tuberculosis (MDR TB)

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

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

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

U50.2 Drug resistant tuberculosis, resistance to rifampicin only

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

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

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

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

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

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

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

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

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

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

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

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

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

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

U50.9 Drug resistant tuberculosis, drug unspecified

²¹ Reference: Document compiled by Nelson Nagoor, Igolide Health Networks, published on the PHISC website <http://www.phisc.org.za/>

U50.90 Drug resistant tuberculosis, primary resistance to drug, unspecified
U50.91 Drug resistant tuberculosis, secondary resistance to drug, unspecified

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

DSN2203 Resistance to antimicrobial and antineoplastic drugs (U82 – U85)

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.

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

The **U60.–** codes must accompany codes from B20 – B24 Human immunodeficiency virus [HIV] disease. These codes are to be used as additional codes.

U60 Drug Resistant HIV

The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014). Compiled by the ICD-10 National Task Team.

U60.0 Resistance to Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)

U60.1 Resistance to Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)

U60.2 Resistance to Protease Inhibitors (PIs)

U60.3 Resistance to Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs) and Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)

U60.4 Resistance to Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs) and Protease Inhibitors (PIs)

U60.5 Resistance to Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs) and Protease Inhibitors (PIs)

U60.6 Resistance to Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs), Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs) and Protease Inhibitors (PIs) (Extensively resistant to most registered antiretrovirals)

U60.7 Resistance to HIV entry inhibitors, alone or in combination

U60.8 Resistance to Integrase inhibitors, alone or in combination or other specified

U60.9 Resistance to antiretrovirals, unspecified

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 **DSN2204 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 **DSN2201 Drug resistant tuberculosis** before assigning U84.3 Resistance to tuberculostatic drug(s).

Summary of changes made to the South African ICD-10 Morbidity Coding Standards and Guidelines document

Please refer to a separate document entitled “Summary of changes made to the South African ICD-10 Morbidity Coding Standards and Guidelines” for all changes made to version 6.

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.

Routine

“Routine” in medical terms means “usual”.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CAT	Computerised Axial Tomography
CMS	Council for Medical Schemes
COIDA	Compensation for Occupational 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
RPL	Reference Price List
SDX	Secondary Diagnosis
URC	Update Reference Committee
WHO	World Health Organisation

References

ICD-10 National Task Team

Extracts from the minutes of the Technical sub-committee, the Communications and Monitoring (Operational) sub-committee and the Training sub-committee Task Team meetings

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

Australian Coding Standards, Volume 5, Third Edition

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Dorland's Medical Dictionary Twenty-third Edition