Questions and answers on ICD10 coding

General overview

ICD-10 is a diagnosis coding standard owned and maintained by the World Health Organisation (WHO). This coding standard was adopted by the National Health Information System of South Africa (NHISSA), and forms part of the health information strategy of the Department of Health. The standard currently serves as the diagnosis coding standard of choice in both the public and private sector.

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

Mandatory Inclusion of ICD-10 Codes on Claims

- 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.
- 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.
- All ICD-10 diagnostic coding must be performed as per the World Health Organisation's official rules and conventions.
- South Africa will continue to use the ICD-10 diagnostic code schema as the National Standard for the foreseeable future.
- In any situation in which a definitive diagnosis is not made, a sign and / or symptom code would be appropriate for use.
- 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.
- 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.

Rationale of the implementation of ICD-10

The rationale behind the implementation of ICD-10 is fourfold:

1. There was a need to standardise data collection processes in the industry.
2. Regulation 5(f) of the Medical Schemes Act 131 of 1998 prescribes the manner of submission of claims by health services.
3. There was a need to facilitate an efficient reimbursement system, for providers that was consistent with legislation and improves risk management practices by medical schemes.
4. The introduction of the Medical Schemes Act in 1999 saw the emergence of a minimum set of guaranteed benefits (PMB's) to be covered by medical schemes. Entitlement to these benefits is diagnosis-driven and is appropriately identified using ICD-10.

Submissions of claims by Healthcare Professionals

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.

May the description of the diagnosis be on the account (electronic or paper)?

No, accounts should only contain the ICD-10 code and NOT the descriptor as well (see the Circular 35 of the Council for Medical Schemes, dated 16 August 2005 for more details).

What is the Standard ICD-10 electronic industry Master Table?

- The standard ICD-10 electronic industry table, available in Excel format from the Department of Health website (www.health.gov.za) must be used as the basis of all ICD-10 coding in South Africa.
- The ICD-10 industry table is updated every July. The latest version has been imported into the ProfNet ICD-10 browser, which is available to subscribing ProfNet members (www.profnetmedical.co.za)

Will I be penalized if my ICD-10 codes are different form the codes submitted by a secondary practitioner?

Health care providers will not be penalized by medical schemes if their ICD-10 codes differ from other providers treating the same patient at the same time. The issue of determining who should decide on the main diagnosis of a patient is beyond the mandate of the ICD-10 Technical Task Team.

Are ICD-10 codes mandatory for pre-authorisations?

"Medical Scheme Regulation 5(f) is specific to the mandatory requirement of a diagnosis code(s) on a claim or account and not for pre-authorisation purposes. Each funder/administrator should streamline their internal process to accept ICD-10 codes when 'offered' by the provider for the purpose of pre-authorisation or use the verbal description given by the member/hospital/doctor for translation into a pre-authorisation/admission code. This admission code must then be updated by the provider(s) as the patient's event progresses or when discharge takes place."

What does "Code to maximum level" mean?

ICD-10 codes have to be coded to the maximum level of specificity (4^{th} and 5^{th} character levels where possible).

Remember, there are only approximately 250 of the 45 000 codes valid as 3 character codes! The rest are all 4 character and 5 character codes.

Not all codes are printed in the coding books as complete 5 characters codes, they are often printed as 3 character codes with a reference to a standard table elsewhere for the 4^{th} and/or 5^{th} characters.

An example: GOUT

If a patient has primary gout of his big toe, the diagnosis code is M10.07

M10	Gout
M10.0	Idioapthic gout
M10.07	Idiopathic gout of big toe (final code)

The 5th character is required to indicate the anatomical site. In Volume 1 of the WHO ICD-10 green book, you will find the options for the different anatomical sites (page p 628 -629).
Use "7" for Ankle and foot (which includes the toes).

5th character subdivisions for use with Gout:

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
9	Site unspecified

EXTERNAL CAUSE CODES – codes starting with S & T
All injury and related codes (all codes starting with an S or T) require an ***additiona****l* code to describe the external cause for the injury. The external cause codes start with a V, W, X or Y and can be found in Chapter 20 of the green WHO ICD-10 books, Volume 1.

Fractured femur sustained when pt fell off chair, injury at home, while doing domestic duties

S72.00	Patient with closed femur neck fracture
W07.03	Injury sustained when pt fell off chair injury at home; doing domestic duties

The code on the account must read S72.00/W07.03

CO-MORBIDITIES AND SECONDARY CODES
It is necessary to code other conditions you are treating as well, and conditions the patient have which might impact on the condition you are treating, or the complexity of your treatment.

Patient with Stroke due to embolism of cerebral arteries with co-morbidity of Hypertensive encephalopathy. Code on the account I63.4/I10

In what sequence must my ICD10 diagnosis codes be?

- First select the most life-threatening/serious clinical condition as the primary/main diagnosis
- Then code the individual conditions followed by all other reportable diagnosis as secondary diagnoses
- Then code complications
- Then code co-morbidities
- And finally code the external causes

Which codes may not be in the primary position?

- All asterisk codes (*) (These codes are additional information)
- Morphology codes (Form or structure of Neoplasms)
- All codes starting with V, W, X and Y (External cause codes)
- Z37.- range (Outcome of delivery)
- B95.- to B97.- range (Bacterial, viral and other infectious agents)
- U50.- range (Multiple drug resistant Tuberculosis)
- U80 – U89 range (Multiple drug resistant organisms)
- Sequelae codes

What is a Sequelae code?

A sequelae code describes the late effects of a condition no longer present as a current illness. Initial condition must no longer be treated and could have occurred one or more years ago. The presenting problem or condition is coded in the primary position. The cause of the Sequelae (previous condition no longer present) is coded as the secondary code e.g.

Dysphagia due to old stroke R13/I69.4
R13 Dysphagia
I69.4 Sequelae of stroke, not specified as haemorrhage or infarction

How do you code a "Questionable diagnosis"?

If a diagnosis is not confirmed, it must not be coded as if the patient suffers from the condition. The basic coding rule is not to assume a condition/diagnosis but to code what is known. Code the presenting symptom or sign – as mostly found in the R codes.

What are the software requirements regarding the number of ICD-10 codes on an account?

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

What ICD10 codes are available for non-disclosure of clinical information?

U98.0 Patient refusal to disclose clinical information
U98.1 Service provider refusal to disclose clinical information

- Consequences of the use of these codes must be clearly understood by the healthcare provider and clearly explained to the patient. According to Regulation 5(f) of the Medical Schemes act, 131 of 1998 diagnostic information must be made available to the medical scheme and failure to do so will influence the reimbursement of such an account. Chronic conditions and prescribed minimum benefit conditions can not be identified and would therefore not be reimbursed accordingly.

- Medical scheme entitlements are based on diagnosis and procedures which determine how much money is made available for each benefit. Thus if the patient or the doctor does not divulge such information, the scheme can rightly question what they are paying for, and might refuse payment for the services rendered

As a supplier of a wheelchair, which ICD10 code do I use?

Z46.8 Fitting and adjustment of other specified devices (Add code to identify the reason e.g. stroke, this code will usually be supplied by the practitioner)

How do I code a consultation for school readiness test?

Z02.2 Examination for admission to educational institution

How do I code an elderly patient that need chest physiotherapy prior to surgery?

Z50.1 Other physical therapy is appropriate for *prophylactic chest physiotherapy*, with
R54 Senility (as secondary code, senility includes normal old age)

With an injury code an External Cause Code must be added but the information can not be obtained from the patient or relatives. Which code must be used?

Y34.99 Unspecified event, undermined intent, unspecified place, during unspecified activity

Why are so many correctly coded injury codes rejected?

Because the practice has failed to include the external cause code as the secondary code. External cause codes have caused a host of rejections, other reasons being:

- the 4th character for the "place of occurrence" were not applied correctly
- the 5th character for the "activity" were not applied correctly
- the sequencing of the external cause coding was not correct (external cause codes may not be in a primary position)

External cause codes will NEVER be a 3 character code!

What questions should I ask to obtain the relevant information regarding the external causes?

"Asking the right questions will give you the right answers"

- **Where** did the accident occur? – e.g. home, school, work.
- **What** where you **doing** at the time of the accident? – playing sport, working.

For Transport accidents, also ask:

- Describe the **mode of transport** of the patient during the accident? – e.g. bicycle, car, pedestrian, horse?
- What was the **patient** in the above vehicle? – e.g. driver, passenger.
- Description of the **other party involved** in the accident? – e.g. motorbike, car, pedestrian.
- In **which area** did the accident occur? – e.g. public or private road.

May "unspecified" codes be rejected by Medical Schemes?

Following ICD-10 codes may not be rejected by Medical Schemes as they are valid codes in the primary and secondary positions:

- 'unspecified' codes that generally end in a .9
- 'other specified' codes that generally end in a .8
- 'sign/symptom' codes that begin with the letter 'R'

How do I code different types of "Falls"?

W00 range Fall on same level involving ice and snow
This code excludes:

- falls with mention of ice-skates and skis (W02.-)
- falls with mention of stairs and steps (W10.-).

Although "ice and snow" is not that prominent in the SA climate, this code is currently used in about 80% of falls-related claims

There are other possible codes that are more relevant like:

- W01 range Fall on same level from slipping, tripping and stumbling
- W06 range Fall involving bed (Includes falling from bed)
- W07 range Fall involving chair (Includes falling from chair)
- W08 range Fall involving other furniture
- W09 range Fall involving playground equipment

Remember to add the 4th and 5th characters
Place of occurrence code (4th character)
Activity code (5th character)

I am a health care professional and pricked myself with a hypodermic needle used to inject a HIV positive patient. How do I code this scenario?

S61.1/W27.22/Z20.6

S61.1 Open wound of finger(s) with damage to nail
(classification of wounds indicate that a puncture wound is a open wound)

W46 Contact with hypodermic needle

Z20.6 Contact with and exposure to human immunodeficiency virus [HIV]
Codes on account: S61.1/W46.22/Z20.6

How do I code syndromes for which there are not specific ICD10 code?

Use the sign and symptoms most prevalent, code that in the primary position and code all the other related information as secondary

Are all sequelae codes conditions that are no longer treated for one year?

Not all the notes at all the sequelae codes indicate it must be older than a year, so take note of the specific notes at the specific codes.

How do I use the* (Asterisk) and † (Dagger) codes?

The dagger code is the primary code and must always be used in the primary position, with the asterisk code in the secondary position. The asterisk code must never be used alone. 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. Claims should not be rejected based on whether the symbols are dropped or maintained in the paper claim environment.

Does ICD10 cater for Arthrosis/Arthritis of specific body regions?

Yes, but it is a common error to code all the hip, knee and hand arthrosis as M19.
These are however specified individually e.g.

M16.- Coxarthrosis [arthrosis of hip]
M17.- Gonarthrosis [arthrosis of knee]
M18.- Arthrosis of first carpometacarpal joint

Remember that: Unilateral and bilateral can only be used if the coder has information to indicate if it was primary or secondary arthrosis. If this information is not available then code to the .9 for unspecified.

M19 Other arthrosis (All other sites except, hip, knee and hands)
& excludes:

- arthrosis of spine (M47.-)
- hallux rigidus (M20.2)
- polyarthrosis (M15.-)

Remember to add a 4th character based on the body site.

How skin ulcers are defined vs diabetic ulcers?

L89 Decubitus ulcer & includes

- Bedsore
- Plaster ulcer
- Pressure ulcer

But excludes decubitus (trophic) ulcer of cervix (uteri) N86

L97 Ulcer of lower limb, not elsewhere classified

The L97 code excludes

- decubitus ulcer (L89)
- gangrene (R02)
- skin infections (L00-L08)
- specific infections classified to A00-B99
- varicose ulcer (I83.0, I83.2)

L98.4 Chronic ulcer of skin, not elsewhere classified & incl

- Chronic ulcer of skin NOS
- Tropical ulcer NOS
- Ulcer of skin NOS

But code L98.4 excludes

- decubitus ulcer (L89)
- gangrene (R02)
- skin infections (L00-L08)
- specific infections classified to A00-B99
- ulcer of lower limb NEC (L97)
- varicose ulcer (I83.0, I83.2)

Is there a specific sequence in HIV coding?

Yes, **B20.- to B24** is sequenced first if the patient is seen for HIV infection or complication due to the presence of the HIV infection. Additional codes are used to identify associated complications.

If the condition of the patient is consulted for is unrelated to the HIV infection the **B20.- to B24** codes will be assigned as secondary codes.

How do I code HIV and Tuberculosis?

When coding Tuberculosis and HIV it is important to establish whether the TB was *due to* the HIV. The patient could have had TB prior to contracting HIV. If the TB was contracted prior to HIV the TB code will be in the primary position, and the other way round as well.

South African Standard:
Conditions classifiable to **two or more subcategories** of the same category should ***NOT*** be coded to the **.7 subcategory** .The decisions has been made to go the ***multiple coding*** route. The codes from within the block B20 - B24 must be used to specify the individual conditions listed.

B22.7 HIV disease resulting in multiple diseases classified elsewhere does not give sufficient statistical information.

Are there specific codes pertaining to HIV counseling?

Z71.7 Human immunodeficiency virus [HIV] counseling

If an HIV patient is asymptomatic, how would this consultation be coded?

Z21 Asymptomatic human immunodeficiency virus [HIV] infection status
HIV positive NOS

Excludes: contact with or exposure to human immunodeficiency virus [HIV] (Z20.6)
human immunodeficiency virus [HIV] disease (B20-B24)
laboratory evidence of human immunodeficiency virus [HIV] (R75)

I am a health care professional and was exposed to the HIV virus. How would I code this?

Z20.6 Contact with and exposure to human immunodeficiency virus [HIV]
Excludes: asymptomatic human immunodeficiency virus [HIV] infection status (Z21)

What is the sequence when coding dementia in HIV?

The † code B22.0 will be in the primary position and the F02.4 for dementia will be in the secondary position.

F02.4* Dementia in human immunodeficiency virus [HIV] disease (B22.0†)
Dementia developing in the course of HIV disease, in the absence of a concurrent illness or condition other than HIV infection that could explain the clinical features.

Final code on account: B22.0/F02.4

Can a family history of HIV be coded?

Yes, use code Z83.0

Z83.0 Family history of human immunodeficiency virus [HIV] disease
Conditions classifiable to B20-B24