USER GUIDE

Technical User Guide compiled by the Ministerial ICD-10 Task Team to define standards and guidelines for ICD-10 coding implementation

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1. Introduction

1.1 Overview and Background

ICD-10 (International Statistical Classification of Diseases and Related Health Problems – Tenth Revision) is a diagnostic coding standard owned and maintained by the World Health Organisation (WHO). The coding standard was adopted by the National Health Information System of South Africa (NHISSA), and forms part of the health information strategy of the National Department of Health (NDoH). The standard currently serves as the diagnostic coding standard of choice in both the public and private healthcare sectors for morbidity coding.

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

Regulation 5(f) of the Medical Schemes Act 131 of 1998 prescribes the manner of submission of claims by healthcare providers and determines that all claims must contain "the relevant diagnostic … code … that relates to the health service". The Council for Medical Schemes (CMS) will provide assistance to the ICD-10 Task Team and measure compliance against Regulation 5(f) of the Medical Schemes Act 131 of 1998 as part of the accreditation of managed healthcare organisations and medical scheme administrators in future

The implementation of the Medical Schemes Act 131 of 1998 also saw the emergence of a minimum set of guaranteed benefits to be covered by medical schemes referred to as Prescribed Minimum Benefits (PMBs). Entitlement to these benefits is diagnoses-driven and is appropriately identified using ICD-10 coding.

To support the NHI (National Health Insurance) and for the purpose of accurate disease statistics, a Ministerial ICD-10 Task Team has been established to advise the Minister of Health on matters pertaining to ICD-10. One of the responsibilities of this Task Team is to ensure that phase 3 and 4.1 of ICD-10 is fully implemented by 1 January 2014.

1.2 Objective(s)

The following table describes the main objectives of the Ministerial ICD-10 Task Team's Technical User Guide:-

01.	Defining clear technical requirements to ensure easy understanding of Phase 3 implementation requirements.	
	O1.1	Ensure the equal compliance within the public and private healthcare sectors.
02.	Implementation of ICD-10 Clinical Validation.	
	O2.1	Assist in a smooth and successful transition from ICD-10 Coding Implementation Phase 3 to Phase 4.
O3.	Ensuring high compliance and accurate ICD-10 statistics by medical schemes, medical scheme administrators and managed healthcare organisations, and by default healthcare service providers in both the public and private healthcare sectors.	
	O3.1	A detailed review of the current ICD-10 compliance data will be undertaken by Council for Medical Schemes (CMS) on behalf of the NDoH.
	O3.2	Findings of O3.1 must be analysed and reported with specific focus on the outstanding requirements of Phase 4 of the implementation process.

1.3 Definitions, Acronyms and Abbreviations

Abbreviation	Term / Definition
BHF	Board of Healthcare Funders
CMS	Council for Medical Schemes
ECC	External Cause Codes
ICD-10	Statistical Classification of Diseases and Related Health Problems – Tenth Revision
ICD-O	International Classification for Oncology
ICD-10 TT	National ICD-10 Task Team
LOA	Level of Acuity
LOS	Length of Stay
MIT	Master Industry Table
MVA	Motor Vehicle Accident
NHISSA	National Health Information System of South Africa
NHI	National Health Insurance
PDX	Primary Diagnosis
PMA	Practice Management Application
PMB	Prescribed Minimum Benefits
SDX	Secondary Diagnosis
WHO	World Health Organisation

1.4 Acknowledgements

The NDoH would like to thank all those participating in the ICD-10 Task Team for offering their time and expertise in the development of the implementation plan.

2. ICD-10 Implementation Phases

A phased approach starting on 1 July 2005 has been followed to implement ICD-10 coding in South Africa as described in the CMS Circular 32 of 2005.

Phase 1: Implementation period from 1 July 2005 to 30 September 2005
Phase 2: Implementation period from 1 October 2005 to 31 December 2005
Phase 3: Implementation period from 1 January 2006 to 01 January 2014
Phase 4: Implementation has been further phased into 4.1. and 4.2.
Phase 4.1: Implementation period starts with displaying warning messages from 01 June 2013 based on the new data requirements i.e. age, gender, morphology codes. This phase will be fully implemented on 1 January 2014 with full claim validation rejections.
Phase 4.2: Implementation details will be finalised in 2013 and communicated to all healthcare stakeholders

In order to be fully compliant with the ICD-10 coding implementation plan, stakeholders must have successfully implemented phase 3 and 4.1 by 01 January 2014.

The requirements for implementation of the phases are described as follows:-

Implementation Requirements		Phase 1	Phase 2	Phase 3	Phase 4
Use all codes (primary and secondary) from the Master Industry Table (MIT)					
Level of specificity of ICD-10 code(s)					
	Minimum 3-characters				
	Maximum level of specificity (3rd, 4th and 5th characters) for all primary and secondary codes				
Sequencing of multiple ICD-10 codes					
	Valid Primary code in first position, followed by secondary codes to a maximum of 10 codes per line item for Medical, Allied and Support Health Professionals and a Valid Primary code in first position, followed by a maximum of 29 codes on a head level for hospital providers				
	Codes invalid for use in first position: Asterisk, Sequelae, or External Cause Code (ECC), etc				

Implementation Requirements		**Phase 1**	**Phase 2**	**Phase 3**	**Phase 4**
Healthcare Providers mandated to submit ICD-10 codes.					
	All diagnosing healthcare providers for all claim items.				
	All non-diagnosing healthcare providers (pharmacists, clinical support and allied healthcare providers) for all PMB claim items.				
	All non-diagnosing healthcare providers (pharmacists, clinical support and allied healthcare providers) for all non-PMB claim items.				
	Hospital claims mandated to submit on highest / header / claim level only.				
	Referral diagnoses to be submitted highest / header / claim level only when available.				
ICD-10 codes per claim item.					
	At least 1 code				
	Full clinical encounter coding For example: two codes describing the disease or condition e.g. injuries with an ECC; irrespective of whether the injury code is in the primary or secondary position, and ECC must follow somewhere in the secondary string				
Clinical Validation					
	Contractual arrangements				
	PMB conditions				
	ICD-10 code not appropriate for Patient age				
	ICD-10 code not appropriate for Patient gender				
	Use of Morphology codes (ICD-O)				

3. ICD-10 Terminology Definitions

Using the above mentioned table describing the requirements for implementation of the different ICD-10 phases, the following sections explain the different ICD-10 terminology in more detail.

3.1 Master Industry Table (MIT)

The MIT is considered the healthcare industry standard for ICD-10 codes and contains all the ICD-10 codes to be used in South Africa. The MIT is distributed as a Microsoft Excel Spreadsheet. The current version of the MIT in use in South Africa is dated September 2007. The updated MIT will be published on 01 January 2013 for implementation on 01 June 2013.

Please refer to Appendix C for full details regarding the content of the MIT.

3.2 Coding Definitions

3.2.1 Primary Diagnosis (PDX) - Morbidity

Definition: The Primary Diagnosis is the main condition being treated. The condition that was diagnosed at the end of the episode of healthcare mainly responsible for the patient's need for treatment or investigation.

If there is more than one "main condition treated", then the most clinically severe or life threatening condition should be selected as the main condition in the primary position.
If this cannot be established then the condition that is responsible for the greatest use of resources should be selected.
Where there is more than one main condition being treated and no information is available to determine which of the conditions is the most severe / life threatening, or which one is responsible for the greatest use of resources go back to the default rule that stipulate the selection of the first condition documented by the treating provider.
If no diagnosis was made, the main symptom, abnormal finding or problem should be selected as the "main condition".
Episodes of healthcare or contact with health services are not restricted to the treatment or investigation of current illness or injury. Episodes may also occur when someone who may not currently be sick requires or receives limited care or services; the details of the relevant circumstances should be recorded as the "main condition".
There can only be one primary diagnosis at the end of the episode of healthcare, primarily responsible for the patient's need for treatment or investigation.
Resources equates to money or overall financial costs. This includes Level of Acuity (LOA), Length of Stay (LOS), equipment, medication etc. as part of the patient's treatment and care. All services will therefore total up to "resource" use for the event or the episode of care.

3.2.2 Primary Code

Definition: The primary code is the code that describes the primary diagnosis, and must appear in the first (primary) position on a claim.

Many patient encounters involve complications or sequelae (late effects) of primary conditions, however a primary underlying condition still exists and this is the condition that defines the primary code.

3.2.3 Secondary Diagnosis (SDX) - Morbidity

Definition: This is an additional condition that affects patient care or may co-exist with the main condition and may require:

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

ECC also fall under secondary diagnoses. Examples are specified in the South African ICD-10 Coding Standards and Guidelines document.

3.2.4 Secondary Code

Definition: Secondary codes are codes that further describe the patient's condition or the cause of the patient encounter.

The secondary codes must follow the primary code and appear in the second to tenth position on a claim line. Examples include diabetic retinopathy, motor vehicle accident (MVA), etc. The rules and conventions of ICD-10 coding as set out by the WHO are applied to assign these codes appropriately (ICD-10 Volume 2 Instruction Manual, Chapter 3)

3.2.5 Valid Code

Definition: A valid code is an ICD-10 code that is published in the MIT based on the WHO rules and conventions.

Example of valid Primary ICD-10 code up to maximum level of specificity:

ICD-10 Code	ICD-10 Description	Valid as a Primary Code
M65.3	Trigger finger	NO
M65.34	Trigger finger, hand	YES
N63	Unspecified lump in breast	YES

Example of valid Secondary ICD-10 code:

ICD-10 Code	ICD-10 Description	Valid as a Primary Code
W01	Fall on same level from slipping, tripping and stumbling	NO
W01.0	Fall on same level from slipping, tripping and stumbling, home	NO
W01.00	Fall on same level from slipping, tripping and stumbling, home while engaged in sports activity	YES

3.2.6 Complete Code / Level of Specificity

Definition: A complete code is an ICD-10 code specified to its maximum level of specificity as published in the MIT based on the WHO rules and conventions.

While most ICD-10 codes are valid up to four and even five characters, there are codes that are valid up to three characters only e.g. I10.

Example of Primary ICD-10 code up to maximum level of specificity:

ICD-10 Code	ICD-10 Description	Maximum Specificity
M65.3	Trigger finger	NO
M65.34	Trigger finger, hand	YES
N63	Unspecified lump in breast	YES

Example of Secondary ICD-10 code up to maximum level of specificity:

ICD-10 Code	ICD-10 Description	Maximum Specificity
W01	Fall on same level from slipping, tripping and stumbling	NO
W01.0	Fall on same level from slipping, tripping and stumbling, home	NO
W01.00	Fall on same level from slipping, tripping and stumbling, home while engaged in sports activity	YES

3.2.7 Complications

Definition: A complication usually arises subsequent to:

an existing condition, disease, pregnancy, injury, etc.;
treatments and procedures;
adverse reactions to drugs and / or chemicals.

A complication may become a primary diagnosis despite it not being the reason for medical treatment. Examples are specified in the South African ICD-10 Coding Standards and Guidelines document.

3.2.8 Co-morbid Conditions

Definition: A pre-existing condition that may or may not increase resource usage and it may co-exist with the main diagnosis. A co-morbid condition may become a primary diagnosis if it is the main condition being treated.

3.2.9 Maternity Codes

Codes O80-O84 (Delivery section in the WHO ICD-10 Volume 1 in chapter XV) should only be used for primary morbidity coding if no other condition classifiable to Chapter XV: *Pregnancy, childbirth and the puerperium* is recorded.

3.2.10 Morphology Codes (ICD-O)

The morphology code records the kind of tumour that has developed and how it behaves. This means that Morphology codes will need to be supplied with all WHO ICD-10 Volume 1 Chapter 2 (Neoplasm) codes where surgery has been performed or where pathology /laboratory investigations have been done to confirm the underlying cell type of the neoplasm.

3.3 Combination Coding

Definition: There are certain diseases or conditions that require a set of two codes to correctly or accurately describe a particular disease or condition.

The following are the four most common examples of Combination Coding:

3.3.1 Sequelae Codes

Definition: Sequelae is the late effect of a condition that is no longer present as the current illness. The initial condition occurred one or more years ago.

A sequelae code can NEVER be used on its own or in the primary position.

Example 1: Dysphagia due to stroke.

PDX: R13 ***Dysphagia***
SDX: I69.4 ***Sequelae of stroke, not specified as haemorrhage or infarction***

Note: The primary diagnosis (PDX) is the late effect: *Dysphagia* and the secondary diagnosis (SDX) is the initial or sequelae condition: *Due to stroke*.

Example 2: The patient presents with osteonecrosis of the pelvic region due to a hip replacement performed 18 months ago after a fracture of the femur was sustained in a motor vehicle accident.

PDX: M87.25 ***Osteonecrosis due to previous trauma, pelvic region and thigh***
SDX: T93.1 ***Sequelae of fracture of femur***
SDX: Y85.0 ***Sequelae of motor-vehicle accident***

Note: The primary diagnosis (PDX) is the late effect: *Dysphagia* and the secondary diagnosis (SDX) is the initial or sequelae condition: *Due to stroke*.

3.3.2 External Cause Codes (ECC)

Definition: ECC allow for the classification of environmental events, circumstances and conditions as the cause of injury, poisoning and other adverse effects.

The South African standard stipulates that all S and T codes must be accompanied by the ECC. ECC must always be used to the maximum level of specificity. Refer the WHO ICD-10 Volume 1 Chapter XIX on Injury, poisoning and certain other consequences of external causes (S00 – T98).

ECC is found in the MIT and also in the WHO ICD-10 Volume 1 Chapter XX External causes of morbidity and mortality (V01 – Y98).

The primary diagnosis (PDX) is the injury or poisoning code and the ECC is the secondary diagnosis (SDX).

An ECC code can NEVER be used on its own or in the primary position.

For example: Open fracture neck of femur due to fall from tree, at home, whilst gardening.

PDX: S72.01: ***Open fracture neck of femur***
SDX: W14.03: ***Fall from tree, at home, whilst engaged in other types of work***

Note: The ECC section requires coding to the maximum level of specificity.

3.3.3 Dagger (+) and Asterisk (*) Codes

Definition: Codes marked with a dagger (+) are considered the primary code indicating the underlying disease, while codes marked with an asterisk (*) are considered optional or secondary codes indicating the manifestation.

A dagger code (+) can be used on its own when there is no manifestation.
An asterisk code (*) can NEVER be used on its own or in the primary position.

There are 83 special asterisk categories listed at the start of the relevant chapters in the WHO ICD-10 Volume 1 book.

For example: Tuberculous peritonitis

PDX: A18.3+: ***Tuberculosis of intestines, peritoneum and mesenteric glands***
SDX: K67.3*: ***Tuberculous peritonitis***

Note: The dagger (+) is the primary diagnosis (PDX) and the asterisk (*) is the secondary diagnosis (SDX).

Note: Not all dagger codes are marked with the symbol (+) and any code, as appropriate, may become a dagger code. Medical schemes may not reject a claim for the reason that a code not marked as such was used as a dagger code together with an asterisk (*) code. All codes to be used for the manifestation are marked with the symbol (*) to indicate that these are asterisks codes.

3.3.4 Local Infections

Definition: Coding of some infections requires an additional code in order to identify the organism(s) that is causing the infection.

For example: Acute cystitis due to E.coli infection

PDX: N30.0: ***Acute cystitis***
SDX: B96.2: ***Escherichia [E.coli] as cause of diseases classified to other chapters***

Note: The site of infection is coded as the primary diagnosis (PDX) and the infecting organism as the secondary diagnosis (SDX).

3.4 Sequencing of ICD-10 Codes

Definition: Determine whether the first code in the primary position on a claim is valid and complete.

A maximum of 10 (ten) ICD-10 codes in total must be allowed for per line item and / or referral diagnoses.

3.5 Placement of ICD-10 Codes on Claims

It is important to understand how to include ICD-10 codes on claims, whether on paper or electronic format.

3.5.1 General

Each ICD-10 code could consist of a maximum of 10 characters.
The primary code is always the first code followed by the secondary / other codes.
The dagger (+) and asterisk (*) symbols are left off all claims.
An upper-or lowercase X is used as a placeholder for the 4th character where a code does not have a 4th character but does have a valid 5th character.
The dot, which is an integral part of an ICD-10 code, is retained in all paper and electronic claim submissions.
Descriptions of diagnoses codes may not be transmitted or printed. Only the ICD-10 codes itself should be transmitted in order to protect patients' privacy and confidentiality.
3-character codes should not contain any dots (.), spaces or hyphens (-).
4- and 5-character codes MUST contain the dot (.) after the 3rd character but SHOULD NOT contain any spaces or hyphens (-).
Electronic claims' submission formats typically dictate the separator to be used between multiple codes:

- Comma- delimited: Use a forward slash (/) without any additional separators like spaces between ICD-10 codes.
- MEDCLM / EDIFACT: Use a forward slash (/) without any additional separators like spaces between ICD-10 codes.
- XML: Different tags will be used for multiple ICD-10 codes

Paper claims: Allow for code, space, forward slash (*/) space, code, repeating until a maximum of 10 ICD-10 codes.
Third parties i.e. switching companies or pharmaceutical benefit management (PBM) companies must maintain the integrity of ICD-10 codes in its original format. Furthermore, the order of the ICD-10 codes may not be changed during transmission and / or translation of data.
Non-disclosure of a diagnosis by the member of a medical scheme or a healthcare provider (U98.-range)

- Under such circumstances, the medical scheme is under no obligation to reimburse the member or the healthcare provider as a claim would still not entirely conform to the requirements of the legislation. Any attempt to do so would constitute non-compliance with prevailing legislation.

3.5.2 Treating / Attending / Admitting Healthcare Provider Claims

ICD-10 codes must be supplied on item level. This means that ICD-10 codes must be supplied on tariff level for all procedures and NAPPI level for all medicines. Modifiers and lab slip items are excluded.
A maximum of 10 (ten) codes in total must be allowed for per line item.

3.5.3 Referring Healthcare Providers Diagnoses

ICD-10 codes should be included from a referring healthcare provider on a claim rendered by a healthcare provider that might not necessarily have 'treated' a patient but is reporting on a patient's medical condition or has provided medical services, e.g. tests or prosthetics, that will assist the treating healthcare provider in addressing a patient's medical condition.
The referral diagnoses could be used to determine a condition(s) of the patient / member in order for the medical scheme to ensure correct benefit allocation.
Refer to CMS Circular 28 of 2009: Including ICD-10 code(s) for referring healthcare providers.
All parties are requested to ensure that fields containing referral diagnoses data are not discarded in the transmission to or at the medical schemes.
Healthcare providers are encouraged to at all times provide ICD-10 code(s) when patients are referred to other healthcare providers.
Existence of the field is mandatory.
ICD-10 codes must be supplied on header / summary / claim level.
A maximum of 10 (ten) codes in total must be allowed for per line item.

3.5.4 Hospital Claims

ICD-10 codes must be supplied on header / summary / claim level.
A maximum of 30 (thirty) codes in total must be allowed for per line item.

3.5.5 ICD-10 codes and Modifiers

No ICD-10 code needs to be submitted for modifier items as the modifier can never be used on its own and will inherit the ICD-10 code from its preceding tariff code.
The only exception to this rule is Medical modifier 0017 which is used as a 'tariff code' and not strictly as modifier.

3.5.6 ICD-10 codes and Dental Laboratory Claims

All Dental Technician claims must include ICD-10 code(s) on line item level.
AND
must also include the referral diagnoses as made by the dentist or dental specialist on header / summary / claim level.

Dentist and dental specialist claims that include dental laboratory work (code 8099) must include the ICD-10 code(s) on the 8099 line item only.
There is no need to repeat this ICD-10 code(s) on the detail of the dental laboratory claim items.

3.6 Clinical Validation

3.6.1 General

ICD-10 codes must be included on all claims / accounts / statements regardless of whether the patient or medical scheme is the recipient and of any payment arrangement between any party in the communication channel.
Only a healthcare provider treating a specific patient / member can select and include an ICD-10 code(s) on a claim / account / statement. No patient or any other third party may do so.
A healthcare provider should use the sign and symptom codes in ICD-10 until such time as he / she can confirm the diagnoses / condition.

3.6.2 PMB Conditions

All members of medical schemes are guaranteed a minimum set of benefits called Prescribed Minimum Benefits (PMBs). The benefits now include a limited set of diagnostic treatment pairs, chronic conditions and emergency medical conditions. The only way to determine if an episode of care constitutes a Prescribed Minimum Benefit is through a diagnosis code.

Medical schemes, administrators and managed care organisations must be able to identify the PMB ICD-10 code, regardless of whether the PMB ICD-10 code is the PDX or SDX.

3.6.3 Different ICD-10 codes on Different Claims

Healthcare providers can not be penalised by medical schemes if their ICD-10 codes differ from that of other healthcare 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 Task Team. The ICD-10 Task Team's role is to assist in slotting in ICD-10 coding into current common practice, and not to interfere with prevailing clinical processes.

3.6.4 Pre-authorisation versus Claims

The following standard response was drafted by the ICD-10 Task Team to explain the use of ICD-10 codes for pre-authorisation versus claim(s) submission:

> "Medical Scheme Regulation 5(f) outlines legislative requirements regarding the manner of submission of a claim. The legislation assumes a discharge diagnosis to be the diagnosis that eventually should be submitted to the medical scheme for reimbursement. It does not however, prescribe the requirements for pre-authorisation. Each medical scheme/administrator should ensure that their internal processes accept ICD-10 codes when submitted by health care providers for the purpose of pre-authorisation or use the verbal description given by the member/health care provider for translation into a pre-authorisation/admission code. The admission code must be updated by the health care provider(s) as the patient's condition progresses or when discharge takes place."

Members and healthcare providers may thus not be refused authorisation if no ICD-10 code but only a description of the condition is available.

3.6.5 ICD-10 codes not appropriate for patient age

During phase 4 of the ICD-10 implementation plan, an 'Age' indicator has been included in the new version of the MIT. This Age indicator must be used to determine when a specific ICD-10 code is clinically appropriate for use. This indicator has been compiled based on the WHO Volume 1 Tabular List.

3.6.6 ICD-10 codes not appropriate for patient gender

During phase 4 of the ICD-10 implementation plan, a 'Gender' indicator has been included in the new version of the MIT. This Gender indicator must be used to determine when a specific ICD-10 code is clinically appropriate for use. This indicator has been compiled based on the WHO Volume 2 Instruction manual, chapter 3 and paragraph 3.1.5: Categories with common characteristics, limited to one sex.

3.6.7 Use of Morphology Codes (ICD-O)

A decision was taken to implement the morphology codes as published in ICD-O Version 3. The list will form part of the MIT planned for 2013. A crossmap from ICD-10 to ICD-0 has not been developed and supplied, hence any morphology code can be assigned to any ICD-10 code.

4.1 Appendix A: Communication with Stakeholders

Year of Publication	Date of Publication	Circular Reference	Circular Title
2004	1 October 2004	46/2004	Implementation of ICD-10 coding
	17 December 2004	58/2004	ICD-10 coding process
2005	14 June 2005	23/2005	Final ICD-10 implementation plan
	28 June 2005	25/2005	ICD-10 coding requirements for clinical support and allied health professionals
	25 July 2005	32/2005	Update on the implementation of ICD-10 coding: all you need to know
	18 August 2005	35/2005	ICD-10 inclusion on claims – Guidelines on usage
	18 August 2005	36/2005	National Task team on implementation of ICD-10 published guidelines on ICD-10 submission – Guidelines are attached to this Circular
	29 September 2005	52/2005	ICD-10 codes for Multi-drug resistant TB
	29 September 2005	53/2005	Extension for submission of ICD-10 codes by blood transfusion services
	3 November 2005	10/2005 (PMB data)	ICD-10 compliance statistics: communication to providers
	7 November 2005	64/2005	National Task team on implementation of ICD-10: collection of high level data from medical schemes
	8 December 2005	12/2005 (PMB data)	Most recent circular with ICD-10 coding for PMB conditions
2006	4 May 2006	21/2006	Postponement of phase 4 of ICD-10 implementation: clinical validation
	10 May 2006	23/2006	Development and use of Quick Reference Code (QRC) lists for ICD-10
	25 July 2006	33/2006	Validity of Unspecified, Other Specified, Sign & Symptom and Default ICD-10 Codes
	28 Sept 2006	42/2006	ICD-10 Version 2 (2005) products and updating of the BHF/DXS ICD-10 master industry table
	28 Sept 2006	43/2006	ICD-10 Coding of Mixtures on Medicine Claims
	15 November 2006	47/2006	Submission of Aggregated ICD-10 Compliance Data
2007	01 Feb 2007	4/2007	SA-Specific ICD-10 Codes for Multi and Extensively Drug-Resistant Tuberculosis
	16 July 2007	19/2007	Submission of Paper Claims With ICD-10 Codes
	16 July 2007	20/2007	Claims Rejection for Invalid or Incomplete ICD-10 Codes
	20 July 2007	21/2007	ICD-10 Master Industry Table 2007 and BHF/DXS Browser - New Edition Available
	13 August 2007	24/2007	Criteria for Coding Training Companies and Trainers to be listed on the CMS Website and the ICD-10 Task Team Review Documents
	24 August 2007	27/2007	The Use of U98 Non-Disclosure ICD10-Codes
	24 August 2007	28/2007	Inclusion of an ICD-10 code at Header Level by referring Healthcare Providers
	04 October 2007	37/2007	National Task Team on ICD-10 Implementation - X59 Exposure to unspecified factor
	06 November 2007	41/2007	Addendum to Circular Number 24 of 2007 - Criteria for Coding Training Companies and Trainers to be listed on the CMS Website and the ICD-10 Task Team review documents

Year of Publication	Date of Publication	Circular Reference	Circular Title
2008	12 March 2008	7/2008	Changes to ICD-10 Master Industry Table
	21 August 2008	23/2008	ERRATA ON THE ICD-10 MIT
	18 December 2008	37/2008	Submission of aggregated ICD-10 compliance data for 2009
2009	8 July 2009	16/2009	Validity of Unspecified, Other specified, Sign & symptom, and Default ICD–10 codes
	3 September 2009	25/2009	Proposed ICD-10 coding to be used for H1N1 ("swine flu")
	3 September 2009	26/2009	Criteria for coding training companies and trainers to be listed on the CMS website and the ICD-10 Task Team review document
	3 September 2009	27/2009	Including ICD-10 code(s) on claims for treating and referring healthcare providers
	3 September 2009	28/2009	Including ICD-10 code(s) for referring healthcare providers
2010	22 February 2010	08/2010	Submission of aggregated ICD-10 compliance data 2010
	23 June 2010	29/2010	Clarification of ICD-10 coding for dental laboratory and technician claims
	23 June 2010	30/2010	ICD-10 codes, pre-authorisation and clinical validation requirements
	23 June 2010	31/2010	ICD-10 coding for non-medical schemes claims
	23 June 2010	32/2010	Purpose of the National ICD-10 Task Team
	24 June 2010	33/2010	The updating of the ICD-10 codes in line with the WHO data
	24 June 2010	34/2010	Review of the ICD-10 Implementation process
2011	02 February 2011	06/2011	Submission of aggregated ICD-10 compliance data 2011

4.2 Appendix B: Notices Published by the National Department of Health

Date of Publication	Notice Title
04 Apr 2012	Appointment of the ICD10 Task Team
15 Jun 2012	ICD-10 coding requirements and training (Circulars 1 and 2 of 2012) Circular 1 of 2012: ICD-10 coding requirements Circular 2 of 2012: Accreditation process of service providers/learners: Diagnostic and procedural coding (SAQA Qualification ID 66389)
15 Jun 2012	South African ICD-10 Coding Standards and Guidelines (Version 5)

http://www.doh.gov.za/list.php?type=Notices

4.3 Appendix C: Explanatory Notes on MIT

The following table describes the information contained within the MIT:

Column	Column Heading	Explanation of Headings	Data Example
A	Number	Sequential numbering of each entry in the MIT data file used maily for sorting purposes.	
B	Chapter_No	Chapter number according to WHO Volume 1 Tabular List.	CHAPTER I
C	Chapter_Desc	Chapter description according to WHO Volume 1 Tabular List.	Certain infectious and parasitic diseases
D	Group_Code	Group code indicates a group of codes that contain clinically similar conditions and follows the conventions of WHO ICD-10 Volume 1 referred to as "block categories".	001
E	Group_Desc	Clinical description of the Group Code, referred to as "block categories in WHO ICD-10 Volume 1.	Intestinal infectious diseases
F	ICD10_3_Code	ICD-10 3-character code, not considered valid for use unless no 4th or 5th character code exists. Used together with Column J Valid_ICD10_ClinicalUse to indicate when valid for use.	A08
G	ICD10_3_Code_Desc	ICD-10 3-character code's description	Viral and other specified intestinal infections
H	ICD10_Code	ICD-10 code to maximum level of specificity. Used together with Column J Valid_ICD10_ClinicalUse to indicate when valid for use.	A08
I	WHO_Full_Desc	WHO long description for ICD-10 code in its 4- and 5-character format.	Viral and other specified intestinal infections
J	Valid_ICD10_ClinicalUse	Indicates whether ICD-10 code listed in column H ICD10_Code is valid for clinical use or not. This is to ensure that only codes up to their maximum level of specificity are used. Indicated as: Y = Code VALID for clinical use N = CODE INVALID for clinical use	N
K	Valid_ICD10_Primary	Indicates whether ICD-10 code is valid in the primary / first position. Indicated as: Y = Code CAN be used in primary / first position N = Code CANNOT be used in primary / first position	N
L	Valid_ICD10_Asterisk	Indicates whether ICD-10 code is an Asterisk code or not. Indicated as: Y = Code IS an asterisk code N = Code IS NOT an asterisk code Please note that the asterisk (*) symbol is included in column H ICD10_Code.	N

Column	Column Heading	Explanation of Headings	Data Example
M	Valid_ICD10_Dagger	Indicates whether ICD-10 code is a Dagger code or not. Indicated as: Y = Code IS a dagger code N = Code IS NOT a dagger code	N
N	Valid_ICD10_Sequelae	Indicates whether ICD-10 code is a Sequelae code or not. Indicated as: Y = Code IS a sequelae code N = Code IS NOT a sequelae code	N
O	Age_Range	Age indicator – only age information mentioned in WHO Volume 1 (Tabular List) added in range format.	
P	Gender	Indicated as: M = Male F = Female U = Unspecified As per WHO Volume 2 Instruction Manual	
Q	Status	South African status indicator for each entry: A = Add D = Discontinue (entry not deleted from file) M = Modify	A
R	WHO_Start_Date	The WHO effective from date for new entries OR effective from date for change to entry to take effect. Date format = CCYYMMDD	20051101
S	WHO_End_Date	WHO discontinued date - when entry is no longer in use. Date format = CCYYMMDD	
T	WHO_Revision_History	WHO revision history of changes made per code as per WHO Corrigendas.	
U	SA_Start_Date	Blank if code existed prior to 2007 MIT version. Value exists if code was added after 2007 or when modification to code took place to indicate when change takes effect. Date format = CCYYMMDD	
V	SA_End_Date	South African discontinued date - when entry is no longer in use. Date format = CCYYMMDD	
W	SA_Revision_History	South African revision history of changes made per code.	
X	Comment	Additional comments per code.	Add new code