ICD-10 Introductory Course

For the

Nambian Association of Medical Aids Funds Namaf

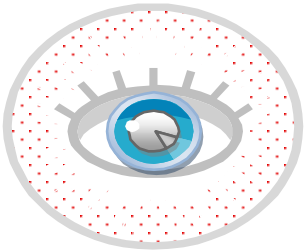
Learner Guide

2025

Prepared & Presented

By

Africode



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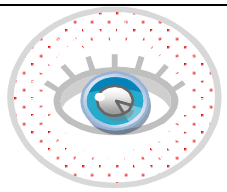
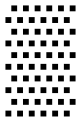
WELCOME!

Welcome to Africode's Introductory ICD-10 Clinical Coding Training. This tailored Introduction to Basic ICD-10 coding course offers foundational knowledge of ICD-10 coding in Namibia and prepares you for the Phase 2.2 and Phase 3 stages of ICD-10 implementation. Clinical Coding, in particular, ICD has evolved from a series of classification that has been revised several times over the last century. ICD can be used to classify diseases and health related problems recorded on many types of health and vital records. The ICD-10 Coding system is a method of translating medical or clinical terminology into codes. ICD-10 Coding involves the use of alpha-numeric codes to describe diseases and health conditions that are arranged in groups for statistical data usage.

This coding programme has been designed and developed by a coding expert to provide you with an introductory knowledge of ICD-10 codes that appear on claims, patient records and or coding databases. ICD-10 Coding programmes are available at different levels, i.e., Introductory or Basic, Full Basic with an assignment, Intermediate and Advanced ICD-10. Coders are sought after in the African Healthcare Industry as this is a scarce skill and coding is business critical to all healthcare stakeholders.

ICONS

The following icons will be used throughout the module.

	**TABLE OF CONTENTS** This provides an outline of the content included in the module as a whole. It is useful for gaining a "birds-eye" perspective on what is to come.
	**GLOSSARY** We provide you with a list of terminology used in the module & an explanation of each so that you can check your understanding.
	**SPECIFIC OUTCOMES** This refers to the specific outcomes that need to be mastered by the end of every unit and that need to be demonstrated in your Portfolio of Evidence upon conclusion of the module.
	**INDIVIDUAL ACTIVITY** This is an opportunity for you to explore your learning and then to check on your progress.
	**Examples** This icon shows you the examples that have been used in explaining terms, rules, conventions and guidelines
	**Important Notes** This icon will enable you to take note of important information, rules, conventions and guidelines

GLOSSARY

TERM	EXPLANATION
Classification of disease	Defined as a system of categories to which morbid entities are assigned according to established criteria
Code number	In ICD-10, this is an alphanumeric code assigned to a disease or condition
Co morbidities	Pre-existing medical conditions or diseases e.g., diabetes, asthma, hypertension, etc
Complication	Any condition a patient presents with after admission into a healthcare facility as a result of the admission
Diagnosis	The determination of the nature of the case of disease, usually based on signs, symptoms and laboratory and other clinical findings
Diagnostic Statement	The diagnosis of the patient
Disease	Any deviation from or interruption of the normal structure or function of part, organ or system of the body as manifested by characteristic symptoms and signs

TERM	EXPLANATION
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision
Morbidity	The incidence or prevalence of a disease; in ICD-10 this refers to coding of diseases and related health problems
Mortality	In ICD-10 mortality coding refers to coding of causes of death
Nosologists	People who are involved in allocation or assigned of codes
Nosology	Study of codes
Principal or Primary diagnosis	Main condition treated or the main diagnosis established after investigation
SACS	South African Coding Standard
Secondary Diagnosis	Any other conditions or diagnoses that require or affect treatment

CODING ABBREVIATIONS

Abbreviation	**Meaning**
CPT	Current Procedural Terminology
DSN	Diagnostic Standard National
DX	Diagnosis
GSN	General Standard National
PDX	Primary diagnosis
SDX	Secondary diagnosis
SACS	South African Coding Standard

OUTCOMES FOR THE COURSE

At the end of this training session, you the learner should be able to:

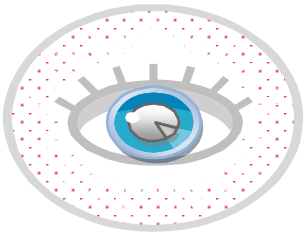
- Understand the background to ICD-10 coding internationally and nationally
- Understand the legal requirements pertaining to ICD-10
- Understand the importance of using a standardised ICD-10 Master Industry Table
- Understand the ICD-10 coding requirements for Phase 2.1, Phase 2.2 and Phase 3
- Explain the use of the ICD-10 reason and rejection codes
- Understand and apply the basic structure and principles of ICD-10
- Understand and apply the combination coding in ICD-10
- Understand the use of sign and symptom ICD-10 codes
- Understand the use of chapter XXI (Z codes)
- Understand and apply the steps involved in ensuring accuracy in coding

Certification
Will be issued by Namaf on successful completion of the course by candidates.

Course Requirements
Before beginning the course, please ensure that you have the following:

- *A copy of the ICD-10 Master Industry Table which is available for download from the Namaf website: https://namaf.org.na/icd-10-master-industry-tables/*

UNIT 1



BACKGROUND TO ICD-10 CODING AND THE ICD-10 REQUIREMENTS FOR THE DIFFERENT PHASES

UNIT 1: BACKGROUND TO ICD-10 CODING AND THE ICD-10 REQUIREMENTS FOR THE DIFFERENT PHASES

1.1. Purpose and Applicability of ICD-10

The ICD stands for International Statistical Classification of Diseases and Related Health Problems, Tenth Revision. The ICD has become the international standard diagnostic classification for all general epidemiological and many health management purposes. These include the analysis of the general health situation of population groups, the monitoring of the incidence and prevalence of diseases and other health problems in relation to other variables, such as the characteristics and circumstances of the individual affected.

The purpose of the ICD is to permit the systematic recording, analysis, interpretation and comparison of mortality and morbidity data in different countries or areas and at different times. The ICD was originally used to classify causes of mortality; its scope was later extended to include diagnosis on morbidity. The ICD is primarily designed for the classification of diseases and injuries with a formal diagnosis, however not every problem or reason for coming into contact with health services can be categorized in this manner, hence chapters XVIII (Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified) and XXI (Factors Influencing Health Status and Contact with Health Services) are provided.

1.2. Background to International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-110)

The ICD-10 is owned by the World Health Organisation (WHO) and revision updates occur every 10-15 years, however ad hoc corrigenda and edition updates occur between revisions. The World Health Organisation inherited the ICD on its 6th revision in 1948. Work on the ICD-10 started in 1983 and the ICD-10 was released for use in 1992. The ICD-10 is used to translate medical

terminology (diagnosis) into an alphanumeric code, which permits easy storage, retrieval and analysis of data. The WHO is responsible for updating and maintaining the ICD every 10-15 years. The newest revision, the ICD-11 has been released by the WHO and is available for adoption and implementation.

1.3. The Use of ICD-10 in Namibia

A letter was circulated by the Namibian Association for Medical Aid Funds (NAMAF) on 20 April 2020 informing healthcare stakeholders that the use of ICD-10 is encouraged on all claims and preauthorisation requests as of 01 June 2020 to assess systems capabilities and any other issues that may arise. NAMAF conveyed the rollout and timelines for the implementation of the International Classification of Diseases and Related Health Problems, ICD-10 into phases. Phase 1 commenced on 01 June 2020, where suppliers of medical services with a practice number were encouraged to commence using ICD-10 codes to familiarize themselves with the coding system, although the use thereof was not mandatory.

In Phase 1, the correct or incorrect use of the ICD-10 code was not material for a valid claim. Phase 1 concluded on 31 March 2025 and Phase 2.1 commenced on 01 April 2025 and is the current phase of implementation. It is envisaged that Phase 2.1. will remain in effect until 31 March 2026 to enable all healthcare stakeholders to prepare for the implementation of Phase 2.2 and Phase 3. The implementation date of Phase 2.2. is planned for 01 April 2026, this date needs to be approved by the Management Committee for Funds and Administrators. Phase 2.2 will remain in effect for 3 months and Phase 3 is planned for implementation on 01 July 2026.

1.4. Requirements for Phase 2.1

To ensure readiness by the revised implementation date, healthcare stakeholders are required to take the following actions:

- Practice Management Software (PMS) must support ICD-10 coding at the line-item level, enabling submission of one primary and up to nine secondary codes per line.
- PMS vendors must ensure that the ICD-10 field is a forced-filed that only allows capture of ICD-10 codes from the ICD-10 Master Industry Table.
- Hospital systems must support ICD-10 coding at the claim header level, allowing for one primary and up to 29 secondary codes.
- Administrator systems must accommodate both PMS and hospital formats to ensure interoperability.
- Administrator systems must be upgraded to accommodate the new alphanumeric ICD-10 reason and rejection codes.
- Switching companies must ensure that their systems support both PMS and hospital formats when transmitting claims.
- Healthcare providers are urged to upgrade their billing systems to software that supports ICD-10 functionality.
- Administrators and Providers should participate in ICD-10 training sessions and workshops.
- Namaf to produce ICD-10 compliance reports and monitor the readiness of stakeholders.
- Administrator claims systems assessments-concluded
- PMS systems assessments-concluded.
- Produce monthly ICD-10 reports: current provider compliance is in the region of 56% (not all providers are submitting claims with ICD-10 codes).
- Through the ICD-10 Task Team, Namaf:
    - Addressed privacy & confidentiality issues-adopted & circulated informed consent forms to providers.
    - Updated and circulated the ICD-10 Technical User Guide to healthcare stakeholders that provides guidance on how to update claims and billing systems.
    - Standardized and circulated ICD-10 reason and rejections codes which administrators are busy catering for in their claims systems.

- Circulated specifications for administrator ICD-10 reports that need to be submitted to Namaf on a monthly basis.

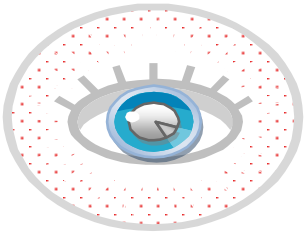
1.5. Requirements for Phase 2.2

- Phase 2.2 is the mandatory phase of implementation.
- During this phase claims with no ICD-10 code or claims that have invalid ICD-10 codes will be rejected.
- At least one ICD-10 at a 3-character level from the ICD-10 MIT must appear on the claim.

1.6. Requirements for Phase 3

- Submission of valid primary ICD-10 codes as per the ICD-10 MIT to continue (first code on the claim-line/header).
- Acceptance of ICD-10 codes for 'unspecified' conditions by administrators (those codes which contained .8 or .9 as a fourth character).
- Acceptance of sign and symptom ICD-10 code/s by administrators, if no definitive diagnosis was made.
- ICD-10 code/s must be valid at the correct level of specificity (correct 3, 4 or 5-character level).
- The first code on the claim must be valid as a primary diagnosis as per the valid pdx flag in the ICD-10 MIT.
- Adhering to the combination coding rules pertaining to dagger and asterisk codes sequelae codes and injury/poisoning and external cause codes.
- Adhere to ICD-10 gender edits as some ICD-10 codes are gender specific.
- Adhere to ICD-10 age edits as a few ICD-10 codes are age specific.

UNIT 2



LEGAL IMPLICATIONS PERTAINING TO ICD-10 AND THE ICD-10 MASTER INDUSTRY TABLE

UNIT 2: LEGAL IMPLICATIONS PERTAINING TO ICD-10 AND THE ICD-10 MASTER INDUSTRY TABLE

2.1. Legal Implications Pertaining to the ICD-10

The ICD-10 code and its description illustrates the diagnosis, abnormal finding or a reason for encounter of healthcare. The ICD-10 codes should be assigned with caution on a patient's healthcare record as the code assigned forms part of the patient's legal documents. The code assigned must reflect the diagnosis made by the medical practitioner or the abnormal findings or reason for encounter of healthcare documented by the practitioner. ICD-10 codes should not be assigned on any healthcare records without any documented supporting evidence by a medical practitioner. Medical practitioners need to work within their scope of practice and only diagnose conditions that their scope allows them to diagnose. The diagnosis can be translated into an ICD-10 code by the practitioner or by a trained coder or case manager. Where a practitioner is unable to make a diagnosis as per his / her scope of practice, a sign or symptom ICD-10 code must be assigned or the referring doctor's ICD-10 code must be assigned if the patient was referred for services by a medical doctor.

Coders or case managers must assign ICD-10 codes based on the documentation of clinical information in a patient's healthcare record. Where clinical information is vague, unclear or missing, it must be clarified with the medical doctor prior to the assignment of the ICD-10 codes. At preauthorisation, the ICD-10 code or the diagnosis made by the doctor must be obtained and translated into an ICD-10 code. Where the diagnosis is not available, the preauthorisation must be based on the sign or symptom ICD-10 code and updated at a later stage when the diagnosis is available. For inpatients, the primary ICD-10 code is assigned at a discharge level. Administrators may not assign ICD-10 codes on behalf of a healthcare provider, change ICD-10 codes or request a provider to change an ICD-10 code.

2.2. Informed Consent

A standardised informed consent form was circulated by Namaf to all healthcare providers who are required to obtain informed consent from patients at every visit or encounter.

- The consent allows providers to disclose clinical information to third parties such as funds and administrators in the form of ICD-10 codes/NBMT codes.
- In the event that a patient refuses to provide consent/allow the disclosure of clinical information or the provider is unable to disclose clinical information, provision is made for the use of U98 codes.
    - U98.0: Patient refusal to disclose clinical information and,
    - U98.1: Service provider refusal to disclose clinical information.
- Code U98.0 is a valid code in the ICD-10 MIT.
- Claims submitted with U98.0 and U98.1 are considered valid for reimbursement under the Phase 2.2 implementation, funds are expected to actively monitor the use of this code and may, at their discretion:
    - directly contact the member as part of their risk management protocol to determine the reason for refusing disclosure and explain the implications of such refusal, especially with regard to the enforcement measures in Phase 3 and beyond.
    - set monetary thresholds within their fund rules to guide whether a claim should be paid or rejected, provided they have first engaged the member via direct telephonic communication.

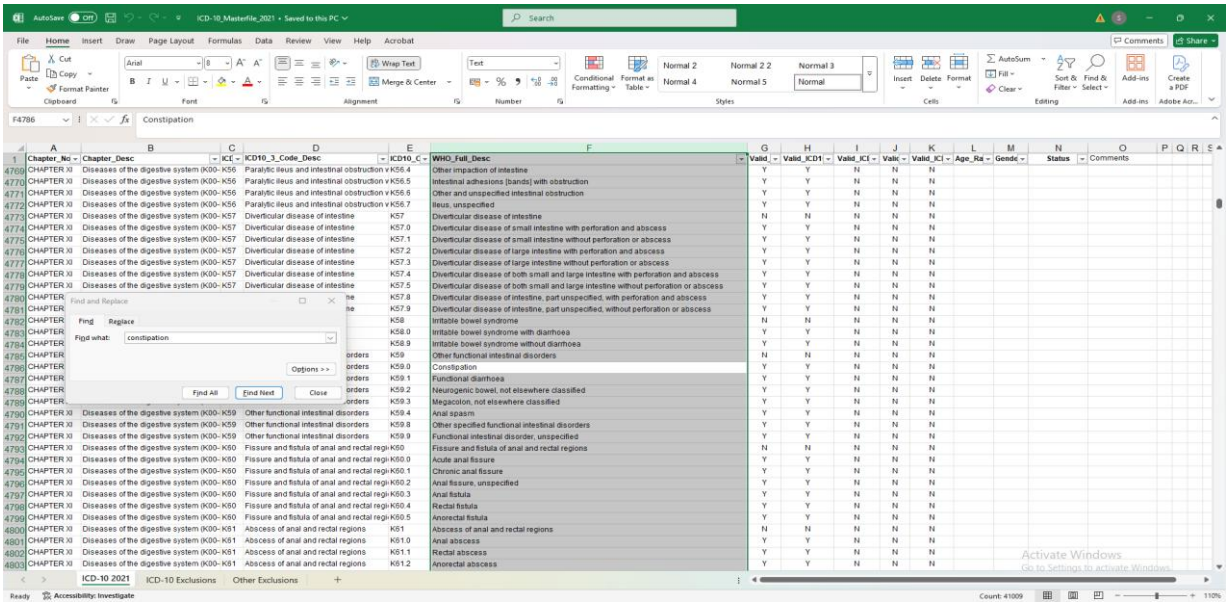
2.3. The ICD-10 Master Industry Table

An ICD-10 Master Industry Table (MIT), an electronic ICD-10 file was made available to all healthcare stakeholders by Namaf. If this is not in place, different stakeholders may use different versions of ICD-10 which can lead to claims rejections and incorrect data collection. Some stakeholders may resort to short lists or customised versions of ICD-10 and this can create frustration

and discord between providers and funders of healthcare. For example, a hospital can submit a correct ICD-10 code on a claim and the claim may get rejected if the administrator does not have the full list of ICD-10 codes that the hospital is utilising. The ICD-10 electronic file needs to be version controlled and updated annually or on a date determined by NAMAF. This file is integrated into all practice management and administrator IT systems.

2.3.1. How to access ICD-10 codes in the ICD-10 MIT

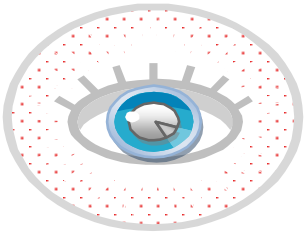
Download the ICD-10 MIT from the Namaf website and save the file. Open the excel file and highlight Column F (full description). On your computer keyboard, press Crtl and F together, then type in the diagnosis you want to assign an ICD-10 code to. Note that excel only allows one-word searches, for example if you type in “constipation” and click on find next or press enter on your key board, the search with bring up code K59.0 Constipation. This code can be assigned to a claim if it is the condition diagnosed by the medical practitioner. If you want to find an ICD-10 code in the ICD-10 MIT, highlight Column E and follow the same process as above. The screen dump below illustrates the search for an ICD-10 code for constipation.



Instruction:

Take a few minutes to view the U98 codes in the ICD-10 MIT

UNIT 3



BASIC STRUCTURE, PRINCIPLES AND ICD-10 REQUIREMENTS FOR PHASE 2.2. AND PHASE 3

UNIT 3: BASIC STRUCTURE, PRINCIPLES AND ICD-10 REQUIREMENTS FOR PHASE 2.2 AND PHASE 3

3.1. Basic Structure, Principles and ICD-10 Requirements for Phase 2.2.

3.1.1. Code structure and length

A minimum of 3-character ICD-10 codes must be assigned by providers from the ICD-10 MIT to all claims, for example:

ICD10_Code	WHO_Full_Description
A00	Cholera

- ICD-10 codes are alphanumeric: 1st character is an alphabet followed by numeric characters.
- The ICD-10 code must not have spaces or hyphens between characters or a dot after the character, unless there are additional characters after the dot.
- The codes must not be case sensitive-can appear in lower or upper case.

3.1.2. ICD-10 coding at a claim level

Medical and allied practitioners

- For medical and allied practitioner claims, the ICD-10 code must appear at a line-item level and every line item must have an ICD-10 code (descriptions not required).
- If one ICD-10 is applicable to all the line items, then the same ICD-10 code will appear on all the lines.
- If the provider diagnosed and treated multiple conditions, different ICD-10 codes may appear on the different lines substantiating the reason for the interventions/procedures performed.
- Modifier lines do not require ICD-10 codes.
- The claim standard for medical practitioners and allied professionals is 10 codes per line item (1 primary and 9 secondary).

- Review the claim example to understand how ICD-10 codes are displayed at a line-item level.

Date	Reference	Patient	Mod	Code	Qty
Transactions with a CxEdi, TxEdi, PxEdi or HBEdi indicated below, have been e					
MediKredit details: L = Levy, S = Surcharge, MM = MMAP Surcharge, D = Disc					
13/06/2013	TxEdi*CONSULTATION A09.9: Gastroenteritis and colitis of unspecified origin	00: ANDREA		0181	1.00
13/06/2013	TxEdi*Intravenous treatment: Intravenous infus A09.9: Gastroenteritis and colitis of unspecified origin	00: ANDREA		0206	1.00
13/06/2013	TxEdi*496125 004 WEBCOL ALCOHOL SWABS [MED16818] A09.9: Gastroenteritis and colitis of unspecified origin	00: ANDREA		0201	1.00
13/06/2013	TxEdi*760838 003 RINGER LACTATE AFB2324 SABAX A09.9: Gastroenteritis and colitis of unspecified origin	00: ANDREA		0201	2.00
13/06/2013	TxEdi*468089 004 SYRINGE & NEEDLE B [21G] A09.9: Gastroenteritis and colitis of unspecified origin	00: ANDREA		0201	1.00
13/06/2013	TxEdi*Urine dipstick, per stick (irrespective A09.9: Gastroenteritis and colitis of unspecified origin	00: ANDREA		4188	1.00
13/06/2013	TxEdi*548021 003 ADM SET ADULT [20DRPADMIA] A09.9: Gastroenteritis and colitis of unspecified origin	00: ANDREA		0201	1.00
13/06/2013	TxEdi*534012 001 PREGNANCY TEST HCG [HOMEMEDFH] A09.9: Gastroenteritis and colitis of unspecified origin	00: ANDREA		0201	1.00
13/06/2013	TxEdi*746924 003 NEUROBION A09.9: Gastroenteritis and colitis of unspecified origin	00: ANDREA		0201	1.00

Hospital providers

- ICD-10 codes from hospitals are to be submitted at a header level.
- The Namibian standard is to cater to for 30 codes (1 primary and 29 secondary) at a header level.
- Depending on the software design, ICD-10 codes may appear at the top or the bottom of the 1st page of the claim.
- Codes can appear one below the other or side by side, sometimes separated by a forward slash.
- Review the claim example to understand how ICD-10 codes are displayed.
- Note that there are no ICD-10 codes at a line-item level.

DIAGNOSIS:
1 SEIZURE / COVID POSITIVE

EFER	TARIFF CODE	DESCRIPTION		SCALE OF BENEFITS	PRIVATE
3052022	58215	HIGH CARE 1.5 DAYS @	8605.50	12908.25	0.00
3052022	58851	PPE HIGH CARE PE 1 UNITS @	490.00	490.00	0.00
3052022	58231	CARDIAC MONITOR 1 UNITS @	403.40	403.40	0.00
3052022	58713	OXYGEN IN WARD P 80 UNITS @	13.40	1072.00	0.00
4052022	58231	CARDIAC MONITOR 1 UNITS @	403.40	403.40	0.00
4052022	58851	PPE HIGH CARE PE 1 UNITS @	490.00	245.00	0.00
4052022	58713	OXYGEN IN WARD P 36 UNITS @	13.40	482.40	0.00
	58	Total Dispensing		0.00	0.00
4052022	58278	WARD MEDICINE		1896.27	0.00
4052022	58272	PRESCRIPTIONS		230.72	0.00
		SUB TOTAL ->		18131.44	0.00
			TOTAL DUE BY ->	18131.44	0.00
			BALANCE OUTSTANDING ->		18131.44

CD10's:

U07.1	99199	(.00)	
R56.8		(26.64)	

3.1.3. Claims validations and rejections

- Administrators are required to conduct claims validations against the ICD-10 MIT.
- If the ICD-10 code submitted on the claim/claim lines does not appear in the ICD-10 MIT or has the incorrect format, it must be rejected with the appropriate reason and rejection code.
- If the claim/claim line does not have an ICD-10 code, it must be rejected with the appropriate reason and rejection code.

3.1.4. Reason and rejection codes

The following reason and rejections codes are applicable for Phase 2.2:

R101: Primary ICD-10 code invalid

- This means that either the ICD-10 code does not exist in the ICD-10 MIT or is not within the current active date range (deleted code no longer in use).

R104: ICD-10 code omitted

- This means that the claim/claim line does not contain an ICD-10.

R110: Cannot read the ICD-10 provided

- This could have several meanings, i.e.:

- For manual claims: ICD-10 code is unreadable or illegible.
- For electronic claims:
  - Truncated or corrupted data: part of the code is cut off or altered during electronic transmission due to formatting or system errors, example: instead of E11.9, you receive just E1, which is not valid.
  - Incompatible character encoding: the system receiving the claim cannot interpret the text encoding used by the sender (especially if non-standard characters or formatting are included).
- Software or Interface Issues: the claims processing system (billing software, switching company, or administrator portal) may have bugs, data mapping issues, or field misalignment.

3.2. Basic Structure, Principles and ICD-10 Requirements for Phase 3

3.2.1. Submission of valid primary ICD-10 codes as per the ICD-10 MIT

(first code on the claim-line/header).

- Refer to the extract from the ICD-10 MIT, in the column Valid Primary, the codes are marked with a N (no) or Y (yes).

ICD10_Code	WHO_Full_Desc	Valid_ICD10_Primary	Comments
A00	Cholera	N	Not valid for assignment
A00.0	Cholera due to *Vibrio cholerae 01*, biovar cholerae	Y	Valid for assignment
A00	Cholera due to *Vibrio cholerae 01*, biovar eltor	Y	Valid for assignment

- If the code has a N and appears on the claim, for e.g. A00, it calls for a rejection only from Phase 3 onwards as A00 is an invalid 3-character code thus it is not valid for assignment. In Phase 2.2 A00 is a valid code and must be accepted.

- A00 has subdivisions/ subcategories or 4-character codes listed below it thus the correct assignment will be A00.0 or A00.1 as these codes are flagged as Y.

Instruction:

Take a few minutes to find A00 in the ICD-10 MIT. Take note of the 4-character codes listed under A00, i.e.A00.0, A00.1 and A00.9

☺ A00 is valid for assignment on claims for Phase 2.2. and cannot be rejected by administrators

3.2.2. Acceptance of ICD-10 codes for 'unspecified' conditions by administrators

- Some codes have a .9 as the 4th character which means that the clinical information is not as specific as it can be.
- For phase 3, these codes are acceptable for use in some situations:
    - for treatment in doctors' rooms/outpatients, e.g. J03.9 Acute tonsillitis unspecified.
    - conditions for which specific information was not available at time of treatment or discharge, e.g. pneumonia-patient was discharged before infecting organism was identified, e.g. J18.9 Pneumonia unspecified.
- For surgical cases, it is important to have the correct information instead of .9 as the patient would have had surgery and the specific information is known to the surgeon/theatre staff, e.g. S74.9 Injury of unspecified nerve at hip and thigh level is inadequate. The correct information needs to be obtained as a case management level to assign the appropriate 4th character, e.g.S74.0 Injury of sciatic nerve at hip and thigh level instead of S74.9.

Instruction:

Take a few minutes to find S74 in the ICD-10 MIT. Note that codes S74.0 to S74.8 provide additional clinical information regarding the nerve that is injured

3.2.3 Acceptance of sign and symptom ICD-10 code/s by administrators

Sign and symptom codes are appropriate in the following situations:

- Patients are treated symptomatically, especially in the providers room, thus it is appropriate to assign sign and symptom codes, such as R12 Heartburn.
- For inpatients, it is appropriate to assign sign or symptoms codes to reflect additional information or reason for investigation/treatment or if no abnormality was detected after investigations, e.g. R50.9 Fever unspecified.
- Non-diagnosing providers are allowed to use sign and symptom codes as their scope of practice disallows them to make a medical diagnosis.
- Signs and symptom codes are appropriate as primary diagnosis codes for sequelae conditions (combination coding).

☺ ***Sign and symptom codes are only to be assigned/accepted as primary diagnosis codes when a diagnosis was not made by the medical practitioner.***

Do not assign sign and symptom codes that are inherent to a diagnosis which is illustrated in the example.

☼ The patient presented to hospital with chest pains. Investigations were conducted and the patient was diagnosed with an acute transmural myocardial infarction of inferior wall. The correct ICD-10 code for this case is I21.1 Acute transmural myocardial infarction of inferior wall. The chest pain must not be coded in addition as it is inherent to a MI, if will be admitting symptom. Once I21.1 is diagnosed, there is no need to code R07.4 Chest pain unspecified in addition.

3.2.4. ICD-10 code/s must be valid at the correct level of specificity

- Some ICD-10 codes are valid for use at a 3-character level, whilst others require 4 or 5 characters to completely describe the diagnosis/condition.

☺ ***The 4 or 5 characters in a code provides additional clinical information about the diagnosis. This enables accurate reimbursement and proper clinical risk management.***

- The Y flag in the ICD-10 MITin the column entitled Valid_ICD-10_Clinical Use indicates the codes that are valid for use at the 3,4- or 5-character level as depicted in the extract from the ICD-10 MIT below.

ICD10_Code	WHO_Full_Desc	Valid_ICD10_ClinicalUse	Comments
A34	Obstetric tetanus	Y	Valid for assignment (3-character code)
A44	Bartonellosis	N	Not valid for assignment
A44.0	Systemic bartonellosis	Y	Valid for assignment (4-character code)
M87	Osteonecrosis	N	Not valid for assignment
M87.0	Idiopathic aseptic necrosis of bone	N	Not valid for assignment
M87.00	Idiopathic aseptic necrosis of bone, multiple sites	Y	Valid for assignment (5-character code)

Instruction:

Take a few minutes to find codes A34, A44 and M87 in the ICD-10 MIT.

A34: take note that there are no 4-character codes listed below A34

A44: take note of the 4-character codes listed below A44

M87: take note of the 5-character codes listed below M87

3.2.5. Adhering to the combination coding rules pertaining to dagger and asterisk codes, sequelae codes and injury/poisoning and external cause codes

a). Dagger and asterisk coding

- Two codes are required to describe the diagnosis of the patient
- Primary code (PDX) is the dagger, marked with a dagger symbol (on software's, this will be a plus sign +, S. A. standard adopted in Namibia). This code takes priority in assignment.
- Additional code is the manifestation, marked with an asterisk symbol.
- If an asterisk code is submitted as the primary code on a claim/line-item, the claim/line item will be rejected as dagger and asterisk codes need to be assigned as a pair.

Enteroviral meningitis

PDX: A87.0+: Enteroviral meningitis

SDX: G02.0*: Meningitis in viral diseases classified elsewhere

Instruction:

Take a few minutes to find A87.0 in the ICD-10 MIT.

You will notice that the asterisk code is provided in the description A87.0 Enteroviral meningitis (G02.0*)

Column J in the ICD-10 MIT has a “Y” indicator which means that A87.0 is a dagger code. The heading for this column is Valid_ICD10_Dagger

Find G02.0 in the ICD-10 MIT. You will notice that column I has a “Y” indicator which means that G02.0 is an asterisk code. The heading for this column is Valid_ICD10_Asterisk

b). Sequelae coding

- Sequelae codes are used to describe the late effects of a condition that is no longer present as a current problem. Original condition must have occurred a while ago.
- Late effects of a sequalae are the reason for treatment.

Poor growth in a child due to sequelae of protein-energy malnutrition

PDX: R62.8 Other lack of expected normal physiological development

SDX: E64.0: Sequelae of protein-energy malnutrition

- If E64.0 is submitted on a claim/claim line as the PDX or 1st code, the claim/claim line will be rejected.

Instruction:

Take a few minutes to find E64.0 in the ICD-10 MIT

Notice that column K has a “Y” indicator identifying E64.0 as a sequelae code

c). Injury, poisoning and external cause coding

Codes from chapter XIX (codes with the alpha character S & T) require additional code/s from chapter XX (alpha characters V, W, X, Y).

☼ Patient was admitted into hospital for treatment of a closed fracture, shaft of femur. This occurred when the patient fell in the yard at home whilst playing.
PDX: S72.30 Fracture of shaft of femur, closed.
SDX: W18.11 Other fall on same level, residential institution, while engaged in leisure activity

Instruction:

Take a few minutes to find S72 in the ICD-10 MIT and view the indicators in column G for S72, S72.3 and S72.30

Then find W18 and view the indicators for W18, W18.1 and W18.11

ICD10_Code	WHO_Full_Desc	Valid_ICD10_ClinicalUse
S72	Fracture of femur	N
S72.3	Fracture of shaft of femur	N
S72.30	Fracture of shaft of femur, closed	Y
W18	Other fall on same level	N
W18.1	Other fall on same level, residential institution	N
W18.11	Other fall on same level, residential institution, while engaged in leisure activity	Y

- The injury code must precede the external cause code.
- Injury codes without ECC codes will result in a rejection of the claim/claim line.

- Both the injury and ECC are coded up to the 5-character level, if coded at the 3rd or 4th character level, the claim/claim-line will be rejected.
    - Valid_ICD10_ClinicalUse has a “Y” indicator at the 5th character level.
    - ICD-10 codes with a “N” indicator in column G, on claims/claim lines with result in a rejection.
- If the ECC appears on a claim/claim line as the PDX or 1st code, the claim/claim line will be rejected as ECC are not valid for assignment as primary codes.
    - In column H Valid_ICD10_Primary, notice that there is a “N” indicator for W18.11 which indicates that this code cannot be assigned as a primary ICD-10 code.

☺ Poisoning and ECC codes are depicted in a similar manner as injury and ECC codes, except poisoning codes are valid at a 4-character level, however ECC codes require 5-character coding. Review codes T39.0 and X40.09 in the ICD-10 MIT.

ICD10_Code	WHO_Full_Desc	Valid_ICD10_ClinicalUse
T39.0	Poisoning, salicylates	Y
X40.09	Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, home, during unspecified activity	Y

3.2.6. Adhere to ICD-10 gender edits

- Some ICD-10 codes are gender specific, thus claims and billing systems must be able to conduct gender validations.
- Claims submitted with gender conflicts for ICD-10 will be rejected.
- The extract the ICD-10 MIT illustrates gender flags for certain codes, M for Male and F for Female. Review these codes in the ICD-10 MIT,

note that for L29.1, column M has a “M” indicator for male and for code N71.0 there is a “F” indicator for female.

ICD10_Code	WHO_Full_Desc	Gender
L29.1	Pruritus scroti	M
N40	Hyperplasia of prostate	M
N71.0	Acute inflammatory disease of uterus	F
N73.5	Female pelvic peritonitis, unspecified	F

3.2.7. Adhere to ICD-10 age edits

- Some ICD-10 codes are age specific and patients age on the claim must be appropriate for the ICD-10 assigned by the provider.
- Claims submitted with age conflicts will be rejected.
- The from the ICD-10 MIT illustrates age flags for certain codes. Review these codes in the ICD-10 MIT. Note that Column L has age ranges for codes M83.03, N92.2, R95.0 and Z00.1.

ICD10_Code	WHO_Full_Desc	Age Range	Comments
M83.03	Puerperal osteomalacia, forearm	> 19 years	Patient must be over 19 years of age
N92.2	Excessive menstruation at puberty	≤19 years	Patient must be 19 years or younger
R95.0	Sudden infant death syndrome with mention of autopsy	≤ 1 year	Patient must be 1 year or younger
Z00.1	Routine child health examination	≤ 19 years	Patient must be 19 years or younger

3.2.8. Reason and rejections codes applicable to phase 3

The following ICD-10 reason and rejections codes will be applicable to Phase 3, in addition to the reason and rejections codes that will be implemented in Phase 2.2.:

R102: The ICD-10 code is invalid in the primary position

Review code Y40.0 in the ICD-10 MIT. Note that the code has a “N” indicator in column H Valid_ICD10_Primary

R103: Primary ICD-10 code incomplete (not to the maximum level of specificity)

Review code N30 in the ICD-10 MIT. Note that the code has a “N” indicator in column G Valid_ICD10_ClinicalUse

R105: Secondary ICD-10 code invalid (code does not exist on MIT or is not within the current active date range)

In column N (heading Status) of the ICD-10 MIT, there are codes flagged with a “D” indicator which means that the code is deleted and no longer in use. Thus, if for example code K35.9 Acute appendicitis, unspecified appears on a claim/claim line, it will be rejected as K35.9 is no longer valid for use

R106: Secondary ICD-10 code incomplete (not to the maximum level of specificity)

Review code W14.0 in the ICD-10 MIT. Note that it has a “N” indicator in column G which means that the code is not at the maximum level of specificity. This code requires a 5th character for example: W14.01 Fall from tree, home, while engaged in leisure activity. W14.01 has a “Y” indicator in column G thus it is a valid secondary ICD-10 code

R107 Dagger code omitted (supplier should amend future accounts)

Review code N33.0 in the ICD-10 MIT. Notice that the code has a “Y” indicator in column I which means that this code is an asterisk code and it cannot be assigned with a dagger code. The corresponding dagger code is A18.1+ which appears in the description of N33.0

R108: Age code incorrect

Review code M41.14 Adult osteochondrosis of spine, thoracic region in the ICD-10 MIT. In the column L the age range is over 19 years (>19 years) thus if this code is used on a patient who is 19 years or younger, it will be rejected. The age range of over 19 years is a World Health Organisation standard for this code

R109: Gender code incorrect

Review code N42.0 The ICD-10 MIT. Note that column M has a “M” indicator for male. If this code is assigned on a female patient, the claim/claim line will be rejected.

R111: ICD-10 external cause code omitted

All codes from chapter XIX (codes with the alpha character S & T) require additional code/s from chapter XX (alpha characters V, W, X, Y).

3.2.9 The Use of Chapter 21 (Z) codes

- Chapter 21 codes describe reasons for contact with health services and not the diagnosis of a patient, therefore not all chapter 21 codes are appropriate as PDX codes.
- These codes will be used as the PDX in some situations, mainly on an outpatient basis and when a patient is seeking a healthcare service but is not actually ill.
- Codes are largely assigned as SDX codes to provide additional information about a patient.

Examples of Chapter 21 codes that are appropriate for use as PDX codes:

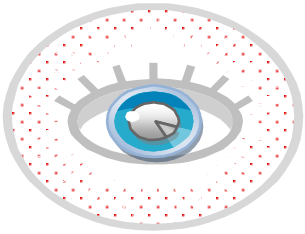
- Z30.2 Sterilization (inpatient)
- Z29.2 Other prophylactic chemotherapy (in or outpatient)
- Z01.2 Dental examination (outpatient)

- Z34.0: Supervision of normal first pregnancy (outpatient)
- Z23.6 Need for immunization against diphtheria alone (outpatient)
- Z13.2: Special screening examination for nutritional disorders (outpatient)
- Z81.4: Alcohol abuse counselling and surveillance (outpatient)

Examples of Chapter 21 SDX codes that are appropriate for use as SDX codes (in or outpatient)

- Z51.1: Chemotherapy session for neoplasm
- Z37.0: Single live birth
- Z50.1 Other physical therapy
- Z59.0 Homelessness
- Z61.7: Personal frightening experience in childhood
- Z65.4: Victim of crime and terrorism
- Z72.0: Tobacco use
- Z80.1: Family history of malignant neoplasm of trachea, bronchus and lung
- Z87.1: Personal history of diseases of the digestive system
- Z99.1: Dependence on respirator

UNIT 4



ACCURACY IN THE ICD-10 CODING

UNIT 4: ACCURACY IN THE ICD-10 CODING

Maintaining accuracy in ICD-10 requires an understanding of the following terms:

- Appropriateness
- Sequencing
- Specificity
- Uniformity

4.1. Appropriateness

- Every line item on a claim must have an appropriate supporting ICD-10 codes.
- Services or resources billed by a hospital must have supporting ICD-10 and when appropriate CPT codes at the header level.
- The ICD-10 and Namaf BMT codes must paint a picture of the patient's episode of care.

4.2. Sequencing

4.2.1. Selection of a primary/principal/main diagnosis

The South African definition of a primary or main diagnosis is aligned to the WHO definition and reads as follows (adopted by Namaf):

"The main condition is defined as the condition, diagnosed at the end of the episode of healthcare, primarily responsible for the patient's need for treatment or investigation. It is the "main condition treated".

If there is more than one such condition, then the condition held most responsible for the greatest use of resources should be selected.
Only in circumstances where there is more than one "main condition" and no information is available to determine which of the conditions is responsible for the greatest use of resources should the coder revert to the

default rule that allows selection of the first condition that the responsible clinician has recorded.

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”.

4.2.2. Definition of secondary or other diagnoses

The definition for other or secondary diagnoses is interpreted as additional conditions that affect patient care in terms of requiring:

- Clinical evaluation: or
- Therapeutic treatment; or
- Diagnostic procedures; or
- Extended length of hospital stays; or
- Increased nursing care and/or monitoring.
- External cause codes also fall under other diagnoses.

- Then code all appropriate complications
  - Complications are conditions that occur after admission to hospital.
  - They are a direct consequence of the admission.
  - E.g.: bleeding, sepsis, rupture of operative wound, etc.
  - Note that a severe complication may become a principal diagnosis if it becomes the “main condition treated”.

- Lastly code all appropriate co morbidities
  - Co morbidities are pre-existing medical conditions e.g.: asthma, diabetes, hypertension etc.

- Co morbidities may or may not increase resource usage in hospital.

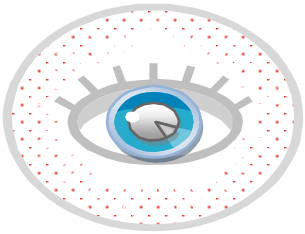
4.3. Specificity

- Only valid 3-character codes as per the ICD-10 MIT must be accepted at the 3-character level from Phase 3 onwards.
- All other codes must be assigned at the correct 4th character sub-category or 5th character level from Phase 3 onwards.
- Where possible, the use of unspecified and symptom and sign codes must be updated at a case management level.
- Combination and multiple coding rules to be followed (dagger, asterisk, poisoning, etc).

4.4. Uniformity

- Follow recommended national/ Namaf standards.
- Follow any in-house standards.
- Uniformity requires that a condition is always represented by the same code each time it is reported.
- Do not make assumptions.

UNIT 5



BENEFITS OF ICD-10

UNIT 5: BENEFITS OF ICD-10

There are numerous benefits in implementing and utilising ICD-10. Depicted below are a few key benefits for stakeholders in Namibia.

References
International Statistical Classification of Diseases and Related Health Problems Tenth Revision, Volumes 1, 2 and 3-World Health Organisation
Namaf circulars and ICD-10 documents
National ICD-10 Implementation Task Team, Review Document-South Africa
South African ICD-10 Coding Standards and Guidelines
Developed by: *Sithara Satiyadev-Certified Professional Coder, October 2025*
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TEST YOURSELF

Circle the correct answer for each of the questions and email your answers to Namaf.

1. ICD-10 is owned by:
   a) Southa Africa
   b) Namaf
   c) The World Health Organisation

2. Phase 2.1 of the ICD-10 implementation is referred to as:
   a) The mandatory phase of implementation
   b) The preparatory phase of implementation
   c) The rejection phase of the implementation

3. During Phase 2.2. of the implementation providers are required to:
   a) Submit ICD-10 codes on a claim from any ICD-10 source
   b) Submit at least one ICD-10 code at a 3-character level from the ICD-10 MIT
   c) Submit a valid primary ICD-10 code from the ICD-10 MIT

4. Healthcare providers are required to obtain informed consent from patients:
   a) Once in a lifetime
   b) At every visit/encounter
   c) Once during the treatment course

5. In phase 3, ICD-10 codes must appear on claims:
   a) Only at a 3-character level
   b) At the maximum level of specificity
   c) At a header level for medical practitioners

6. In phase 3, asterisk codes
   a) Can be assigned as primary codes
   b) Must be preceded by a dagger code
   c) Are not valid for use

7. In phase 3 all injury and poisoning codes on claims must:
   a) Have an external cause code
   b) Must be coded at a 5-character level
   c) Must be coded at a 4-character level

8. Reason and rejection code R101 means:
   a) Primary code is missing
   b) Primary code is invalid
   c) Primary code requires a secondary code

9. Reason code R109 means:
   a) Age is inappropriate for the ICD-10 code on the claim
   b) Gender is inappropriate for the ICD-10 code on the claim
   c) The codes is appropriate for both male and female patients

10. Sign and symptom codes:
   a) Are not be to be used by healthcare providers
   b) Can only appear on claims as secondary codes
   c) Are valid as primary and secondary codes in certain situations

11. Non-diagnosing providers:
   a) May use sign and symptom and chapter 21 (Z codes) on their claims
   b) May omit ICD-10 codes on claims
   c) May call the administrator for an ICD-10 code

12. Chapter 21 (Z codes) may only be used as:
   a) Primary ICD-10 codes
   b) Primary and secondary ICD-10 codes
   c) Secondary ICD-10 codes

13. The primary diagnosis is:
   a) The main condition treated
   b) The most life threatening and most resource intensive condition
   c) All of the above

14. When acute conditions and co-morbidities are treated:
   a) Only the ICD-10 for the acute conditions must appear on the claim
   b) Only the ICD-10 for the co-morbidity must appear on the claim
   c) The ICD-10 codes for both the acute condition and co-morbidity must appear on the claim

15. Claims that have ICD-10 codes with a .9 (unspecified) as the 4th character must be:
   a) Rejected
   b) Part paid
   c) Paid in full

Answers to Test Yourself

1. C
2. B
3. B
4. B
5. B
6. B
7. A
8. B
9. B
10. C
11. A
12. B
13. C
14. C
15. C