PHISC
Private Healthcare Information Standards Committee

PHISC Addendum to the South African ICD-10 Morbidity Coding Standards and Guidelines document

Proposal from the PHISC ICD-10 Technical Workgroup of the PHISC Clinical Coding subcommittee

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Version	Date	By Whom	Changes
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Acknowledgement

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Introduction and Disclaimer

This addendum has been compiled with the aim of documenting ICD-10 coding standards and guidelines suggested by PHISC, for use IN ADDITION TO The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (April 2014) as officially published for South Africa on the website of the National Department of Health. This addendum does not serve as a training document and is not regulated for use; it is a de-facto PHISC guide to further assist the user in the standardised use of ICD-10.

Coding Standards are:

1. Developed to assist the clinical coder.
2. Developed to keep a record of and track coding standards and guidelines as agreed on by PHISC.
3. To be used concurrently with the South African ICD-10 Morbidity Coding Standards and Guidelines document, the ICD-10 manuals and training material.

User Guide

A standard

- a specification by which something may be tested or measured (specification – details describing something to be done)
- the required level of quality

A guideline

- a statement of principle giving general guidance

PGS0001
PGS – PHISC General Standard
GS00 – Relates to General Coding Standards
01 – A unique number allocated to the standard

PCS0101
PCS – PHISC Chapter Specific Standard
CS01 – Relates to Chapter Specific Standards
01 – A unique number allocated to the standard

Symbols used

 Please reference the South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014) when this symbol is displayed.

PHISC General Morbidity Coding Standards and Guidelines

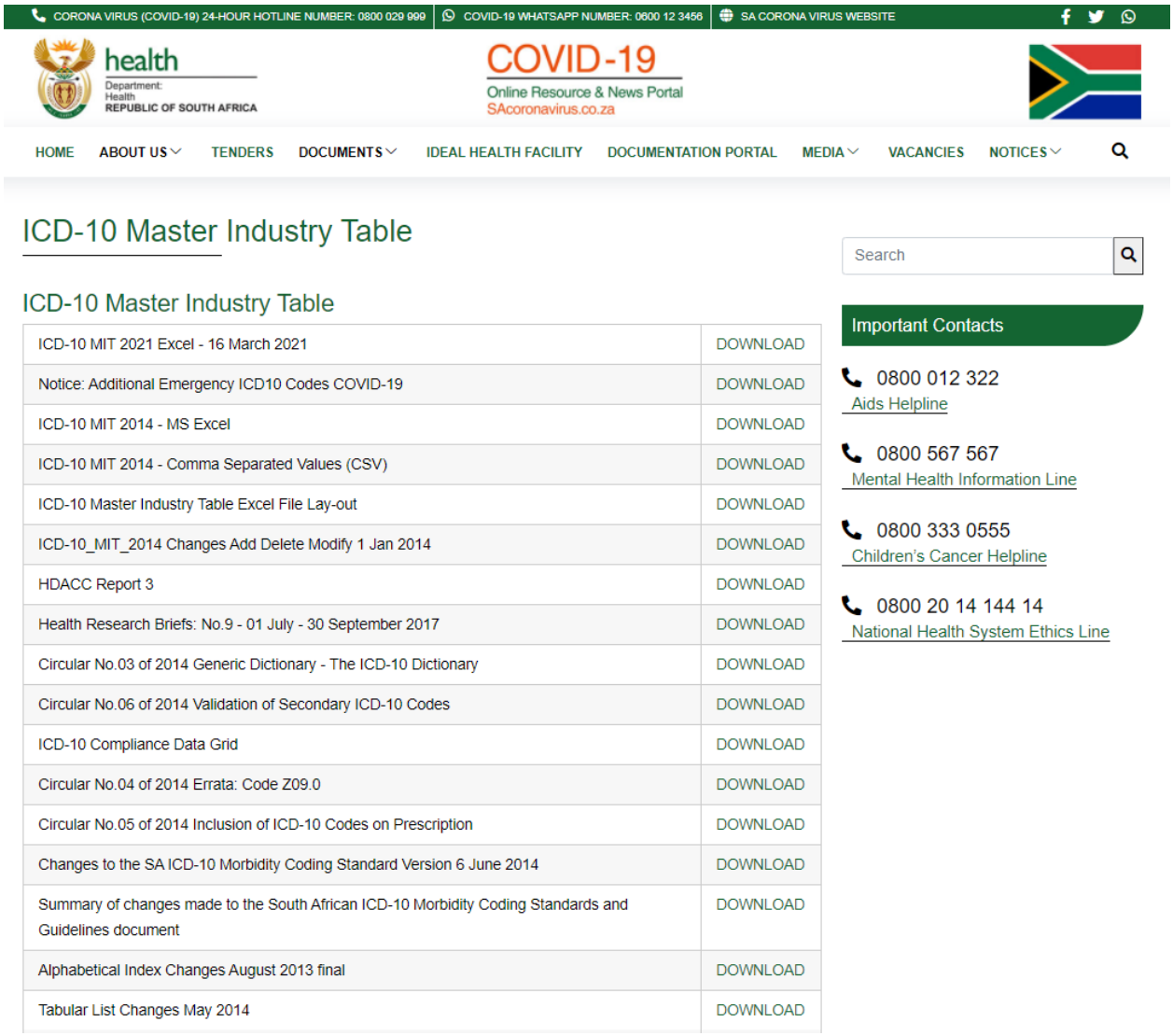
PGS0001 **Version of ICD-10 used in South Africa**

Caution regarding different versions of ICD-10

Please note that not all reference to ICD-10 on the internet is referring to the World Health Organisation (WHO) edition of ICD-10. In South Africa, we use the WHO 'vanilla' version of ICD-10, with a few local code additions. The SA ICD-10 Master Industry Table (MIT), 16 March 2021 (containing all WHO Corrigenda updates until January 2014 and the additional ICD-10 codes for emergency use to cater for COVID-19 related conditions and syndromes), is the ONLY official reference list for ICD-10 codes appropriate for use in South Africa.

The American ICD-10-CM (Clinical Modification), the new diagnostic coding system replacing ICD-9-CM in America is also referred to as ICD-10 on the internet. This is a very different set of codes, although based on ICD-10, a clinical modification has been done and some of the codes now have up to 7 characters (Format: XXX.XXXX). These are not appropriate for use in South Africa. The WHO also have a version of ICD-10 (2016) available in electronic look-up format on their website but this does not contain the South African local codes or specific rules for use of the code set in South Africa.

It is thus vital to always cross-reference your ICD-10 codes to the SA MIT to ensure adherence to local industry requirements. The MIT can be freely downloaded from the website of the National Department of Health: http://www.health.gov.za/icd-10-master-industry-table/



CORONA VIRUS (COVID-19) 24-HOUR HOTLINE NUMBER: 0800 029 999 | COVID-19 WHATSAPP NUMBER: 0600 12 3456 | SA CORONA VIRUS WEBSITE

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

COVID-19
Online Resource & News Portal
SAcoronavirus.co.za

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ICD-10 Master Industry Table

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ICD-10 Master Industry Table

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Important Contacts

0800 012 322
Aids Helpline

0800 567 567
Mental Health Information Line

0800 333 0555
Children's Cancer Helpline

0800 20 14 144 14
National Health System Ethics Line

PGS0002 **ICD-10 Quick Reference Code (QRC) lists or Short lists**

The use of ICD-10 Quick Reference Code (QRC) lists / short lists / "cheat-sheets" is not recommended as this compromises coding accuracy affecting health information data used for epidemiology, disease management, re-imbursement e.g. prescribed minimum benefits (PMB's), etc.[1]

PGS0003 **Gender edits for specific procedures/scenarios**

Existing gender flags will not be changed to accommodate certain procedures that conflict with the patient's gender. Each organization must have the ability to override the gender edits for specific procedures/scenarios.

Refer to "7.8 List of code categories limited to, or more likely to occur in, just one sex" as per the WHO ICD-10 Instruction Manual (Volume 2), Fifth edition, 2016

7.8.1 List of categories limited to, or more likely to occur in, female persons
7.8.2 List of categories limited to, or more likely to occur in, male persons

PGS0004 **Age edits for certain diagnoses**

Existing age flags will not be changed to accommodate certain diagnosis/es that conflict with the patient's age. Each organization must have the ability to override the age edits for specific diagnoses.

PGS0005 **Healthcare Provider specific code assignment**

 **GSN**0001 **Primary Diagnosis**

 **GSN**0002 **Secondary Diagnosis/es**

Most of the coding examples and scenarios cater for in-hospital coding. Not all the ICD-10 codes assigned for these examples and scenarios will apply to the different practice types. The coding may differ depending on the treating healthcare provider's specialty or the facility. Please assign codes accordingly and consider the value additional codes will have on your data set.

[1] Reference: ICD-10 Implementation Review January 2004 – March 2010.

PGS0006 **The dagger and asterisk system**

📖 **GSN**0016 **Dagger and asterisk system / convention**

The dagger code is to be repeated with each asterisk code even if the dagger code is the same.

Example 1:
Patient admitted with viral pneumonia due to COVID-19. Patient was also treated for a pleural effusion as a result of COVID-19.

PDX: U07.1+ (COVID-19, virus identified)
SDX: J17.1* (Pneumonia in viral diseases classified elsewhere)
SDX: U07.1+ (COVID-19, virus identified)
SDX: J91* (Pleural effusion in conditions classified elsewhere)

Example 2:
Diabetic cataract and retinopathy

PDX: E14.3+ Unspecified diabetes mellitus with ophthalmic complications
SDX: H28.0* Diabetic cataract (E10-E14+ with common fourth character .3)
SDX: E14.3+ Unspecified diabetes mellitus with ophthalmic complications
SDX: H36.0* Diabetic retinopathy (E10-E14+ with common fourth character .3)

- An asterisk code must always be preceded by a dagger code.
- Multiple asterisk codes should not be assigned with one dagger code.
- Each asterisk code must have its own dagger code, even if the dagger code is repeated.

ICD-10 codes that can be assigned as dagger codes

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

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

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

Reference: GSN0016 Dagger and asterisk system / convention, The South African ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014).

PHISC addition:

Most ICD-10 codes are considered to be dagger codes.
Apart from the asterisk codes, the following codes cannot be assigned as dagger codes:

- Sequelae codes
- Bacterial, viral and other infectious agents (B95-B98)
- Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00 – P04)
- Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00 – R99)
- External cause codes (ECCs)

- Factors influencing health status and contact with health services (Z00 – Z99)
- Morphology codes
- Drug resistant tuberculosis (U50.–)
- Drug resistant HIV (U60.–)
- Resistance to antimicrobial and antineoplastic drugs (U82.–, U83.–, U84.– and U85)
- Non-disclosure of clinical information (U98.0 and U98.1)
- Death codes

Some XXII (U-codes) can be assigned as dagger codes. Refer to COVID-19 coding scenarios in the PHISC Addendum to the ICD-10 Morbidity Coding Standards and Guidelines document where U-codes can be assigned as dagger codes.

Coding sequence of external cause and asterisk codes

Example:
Patient developed osteonecrosis due to Caisson disease. Developed decompression sickness following scuba diving.

PDX: T70.3+ Caisson disease [decompression sickness]
SDX: M90.39* Osteonecrosis in caisson disease (T70.3+), site unspecified
SDX: T70.3 Caisson disease [decompression sickness]
SDX: W94.99 Exposure to high and low air pressure and changes in air pressure, unspecified place, during unspecified activity

PHISC Chapter Specific Coding Standards and Guidelines

PCS01 Certain infectious and parasitic diseases (A00 – B99)

PCS02 Neoplasms (C00 – D48)

PCS03 Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50 – D89)

PCS04 Endocrine, nutritional and metabolic diseases (E00 – E90)

PCS05 Mental and behavioural disorders (F00 – F99)

PCS06 Diseases of the nervous system (G00 –G99)

PCS07 Diseases of the eye and adnexa (H00 – H59)

PCS08 Diseases of the ear and mastoid process (H60 – H95)

PCS09 Diseases of the circulatory system (I00 – I99)

PCS10 Diseases of the respiratory system (J00 – J99)

PCS11 Diseases of the digestive system (K00 – K93)

PCS12 Diseases of the skin and subcutaneous tissue (L00 – L99)

PCS13 Diseases of the musculoskeletal system and connective tissue (M00 – M99)

PCS14 Diseases of the genitourinary system (N00 – N99)

PCS15 Diseases of Pregnancy, Childbirth and the Puerperium (O00 – O99)

PCS16 Certain conditions originating in the perinatal period (P00 – P96)

PCS17 Congenital malformations, deformations and chromosomal abnormalities (Q00 – Q99)

PCS18 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00 – R99)

PCS19 Injury, poisoning and certain other consequences of external causes (S00 – T98)

PCS20 External causes of morbidity and mortality (V01 – Y98)

PCS21 Factors influencing health status and contact with health services (Z00 – Z99)

PCS22 Codes for special purposes (U00 – U99)

PCS01 Certain infectious and parasitic diseases (A00 – B99)

PCS0101 **ICD-10 codes to be assigned for Enterococcus Faecalis**

Example 1:
Patient admitted with a urinary tract infection, causative organism Enterococcus Faecalis

PDX: N39.0 Urinary tract infection, site not specified
SDX: B95.2 Streptococcus, group D, as the cause of diseases classified to other chapters

Example 2:
Patient admitted with a urinary tract infection, causative organism Enterococcus Faecalis, noted as resistant to multiple antimicrobial drugs

PDX: N39.0 Urinary tract infection, site not specified
SDX: B95.2 Streptococcus, group D, as the cause of diseases classified to other chapters
SDX: U84.7 Resistance to multiple antimicrobial drugs

PCS0102 **ICD-10 codes to be assigned for invasive non-typhoidal salmonella caused by the Novel Pathogen**

Assign codes as follows:
PDX: A02.8 Other specified salmonella infections
SDX: B96.8 Other specified bacterial agents as the cause of diseases classified to other chapters

PCS0103 **ICD-10 code to be assigned for Sindbis virus (SINV)**

Assign **A92.8 Other specified mosquito-borne viral fevers** for Sindbis virus (SINV)

PCS0104 **ICD-10 code to be assigned for Extended Spectrum Betalactamase (ESBL)**

Assign an ICD-10 code for the infection followed by **U82.2 Extended spectrum betalactamase (ESBL) resistance**.

PCS0105 **ICD-10 code to be assigned for MERS virus**

Middle East respiratory syndrome (MERS) is a viral respiratory disease caused by a novel coronavirus (MERS-CoV) that was first identified in Saudi Arabia in 2012[2].

Assign as follows:

Example 1:
Patient admitted with severe acute respiratory syndrome (SARS) caused by Middle East Respiratory Syndrome (MERS)

PDX: U04.9 Severe acute respiratory syndrome, unspecified
SDX: B97.2 Coronavirus as the cause of diseases classified to other chapters

Example 2:
Patient admitted with respiratory distress syndrome caused by Middle East Respiratory Syndrome (MERS)

PDX: J80 Adult respiratory distress syndrome
SDX: B97.2 Coronavirus as the cause of diseases classified to other chapters

PCS0106 ICD-10 code to be assigned for Zika virus
Based on the inputs received from members of the PHISC ICD-10 Technical Workgroup, the following recommendations have been made for ICD-10 coding of the Zika virus:

Assign **U06.9 (Zika virus disease, unspecified)** if there is a positive PCR test for the Zika virus.

For Zika virus disease complicating pregnancy, childbirth and the puerperium, assign **O98.5 (Other viral diseases complicating pregnancy, childbirth and the puerperium)** as the primary diagnosis and **U06.9 (Zika virus disease, unspecified)** as the secondary diagnosis.

For congenital Zika virus disease, assign **P35.8 (Other congenital viral diseases)** as the primary diagnosis and **U06.9 (Zika virus disease, unspecified)**as the secondary diagnosis.

For Zika virus disease maternal, affecting fetus or newborn, assign **P00.2 (Fetus and newborn affected by maternal infectious and parasitic diseases)**.

 **DSN**1603 **Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00 – P04)**

There are two new codes for Zika virus. These are currently not valid for use as per the South African ICD-10 (MIT).
A92.5 Zika virus disease
P35.4 Congenital Zika virus disease

Reference: WHO ICD-10 Browser

 Refer to **PGS**0001 **Version of ICD-10 used in South Africa**.

[2] http://www.who.int/mediacentre/factsheets/mers-cov/en/

PCS0107 **ICD-10 code to be assigned for Carbapenem-resistant Enterobacteriaceae (CRE) or carbapenemase-producing Enterobacteriaceae (CPE)**

Assign an ICD-10 code for the infection followed by **U82.8 Resistance to other betalactam antibiotics**.

PCS0108 **ICD-10 code to be assigned for viral haemorrhagic fever due to Lujo virus**

Assign A96.8 (Other arenaviral haemorrhagic fevers) for Lujo virus.

PCS0109 **ICD-10 codes for Dengue fever**

The following codes are valid on the SA ICD-10 MIT:
- A90 Dengue fever [classical dengue]
- A91 Dengue haemorrhagic fever

There are four new codes for Dengue. These are currently not valid for use as per the South African ICD-10 (MIT).
- A97.0 Dengue without warning signs
- A97.1 Dengue with warning signs
- A97.2 Severe Dengue
- A97.9 Dengue, unspecified

Reference: WHO ICD-10 Browser

📖 Refer to **PGS**0001 **Version of ICD-10 used in South Africa**.

PCS0110 **ICD-10 codes for Chronic viral hepatitis**

The following codes are valid on the SA ICD-10 MIT:
- B18.0 Chronic viral hepatitis B with delta-agent
- B18.1 Chronic viral hepatitis B without delta-agent
- B18.2 Chronic viral hepatitis C
- B18.8 Other chronic viral hepatitis
- B18.9 Chronic viral hepatitis, unspecified

The addition of a fifth character code “0” to indicate “immune-tolerant phase” and “9” to indicate “other and unspecified phase” is currently not valid for use as per the South African ICD-10 (MIT).

Reference: WHO ICD-10 Browser

📖 Refer to **PGS**0001 **Version of ICD-10 used in South Africa**.

PCS0111 **ICD-10 code for Shiga Toxin-Producing Escherichia coli**

B96.2 (Escherichia coli [E. coli] as the cause of diseases classified to other chapters) is the closest option.

Example:
Patient admitted with gastroenteritis, severe stomach cramps, diarrhoea, nausea and vomiting. The patient's temperature is 38.2°C.
Pathology results indicate the presence of a SHIGA Toxin producing E-Coli

PDX: A09.0 Other and unspecified gastroenteritis and colitis of infectious origin
SDX: B96.2 Escherichia coli [E. coli] as the cause of diseases classified to other chapters

The symptoms of fever, nausea and vomiting are not coded in addition.
Symptoms of Shiga toxin-producing E. coli (STEC) infection vary for each person, but often include severe stomach cramps, diarrhoea (often bloody), and vomiting. Some people may have a fever, which usually is not very high (less than 101˚F/38.5˚C).

PCS0112 **Coding of Sepsis**

Systemic Inflammatory Response Syndrome (SIRS) is a widespread, exaggerated inflammatory reaction by the body to a harmful stressor such as infection, trauma, or surgery. This response can lead to severe systemic inflammation, which may result in reversible or irreversible organ dysfunction and, in severe cases, death. SIRS is identified by clinical signs including abnormal body temperature, elevated heart and respiratory rates, and abnormal white blood cell counts. When SIRS occurs in the presence of a confirmed infection with at least two of these symptoms, it is classified as **sepsis**.

Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency. Sepsis happens when an infection you already have triggers a chain reaction throughout your body. Most cases of sepsis start before a patient goes to the hospital. Infections that lead to sepsis most often start in the lung, urinary tract, skin, or gastrointestinal tract. Without timely treatment, sepsis can rapidly lead to tissue damage, organ failure, and death.
https://www.cdc.gov/sepsis/what-is-sepsis.html (Accessed 09/10/2023)

Sepsis a continuum. Sepsis progresses through three stages, each more severe than the last: SIRS → Severe Sepsis → Septic Shock.

Severe Sepsis is defined as sepsis accompanied by **organ dysfunction**, **hypoperfusion**, or **hypotension**, indicating a more critical progression of systemic infection. Clinical manifestations of organ dysfunction may include:

- **Oliguria** (decreased urine output)
- **Acute mental status changes** (e.g., confusion, delirium)
- **Thrombocytopenia** (low platelet count)
- **Respiratory distress** or **hypoxemia**
- **Cardiac impairment** (e.g., reduced ejection fraction or arrhythmias)
- **Abdominal pain** due to gastrointestinal hypoperfusion or ischemia

Septic shock represents the most critical stage of sepsis, characterized by persistent hypotension and tissue hypoperfusion despite adequate fluid resuscitation. It is often accompanied by elevated lactate levels and other markers of circulatory and cellular/metabolic dysfunction. Septic shock carries a significantly higher mortality risk, with death rates ranging from 30% to 50%, and may be even higher in vulnerable populations or under suboptimal care conditions.

A **localized infection** is confined to a specific part of the body, such as the lungs, or urinary tract, and does not spread beyond its initial site.

A **generalized or systemic infection** occurs when an infectious agent such as a bacterium, virus, fungus, or parasite enters the bloodstream and spreads throughout the body. This widespread dissemination can lead to serious, potentially life-threatening complications, including sepsis or can lead to severe, life-threatening conditions like sepsis.

Primary and Secondary Sepsis
Bloodstream infections occur when bacteria, fungi or other pathogens enter the bloodstream and multiply, potentially causing systemic infection.

They are generally classified into two categories: **primary bloodstream infections**, originating directly in the blood (e.g., catheter-related infections), and **secondary bloodstream infections**, arising from other infected tissues like lung (pneumonia), abdomen or urinary tract infections.
Bloodstream Infections (BSIs) and Common Pathogenic Bacteria (Accessed 23/07/2025)

Neutropenic Sepsis
Neutropenic sepsis is a serious medical emergency, commonly seen in oncology and haematology patients, defined as the presence of a neutrophil count of ≤0.5 × 109/L together with a temperature of ≥38°C or other signs of significant sepsis. It occurs when a person with neutropenia (a low level of neutrophils, a type of white blood cell) develops sepsis—a dysregulated host response to infection that leads to organ dysfunction. Neutropenia makes it difficult for the body to fight off infections, and when combined with sepsis, the condition can rapidly become life-threatening, requiring rapid assessment and empirical antibiotic therapy.

Transient neonatal neutropenia
Transient neonatal neutropenia (TNN) is a benign condition usually due to maternal factors. It is characterized by a low absolute neutrophil count (ANC) in a newborn.

Neonatal neutropenic sepsis
Neonatal neutropenic sepsis (NNS) is a severe systemic infection occurring in a neonate in association with neutropenia (reduced absolute neutrophil count), resulting in an increased susceptibility to severe bacterial and fungal infections and may rapidly progress to life-threatening organ dysfunction.

- Assign a code from Bacterial sepsis of newborn (P36.0 – P36.9) as the primary diagnosis for sepsis occurring during the perinatal period.
- Assign D70 (Agranulocytosis) for the Neutropenia
    - ❖ Sequencing should follow the primary diagnosis definition. While sepsis is most commonly the cause of neutropenia, in rare cases, neutropenia can also cause sepsis. The primary diagnosis must be assigned in accordance with the current definition of primary diagnosis outlined in **GSN**0001 **Primary Diagnosis**.
- Do not assign code P61.5 (Transient neonatal neutropenia) for infection-related neutropenia, as this is for transient cases unrelated to sepsis.
- Assign codes for associated conditions and any additional findings, such as fever or specific organ dysfunction.

<u>Neonatal Neutropenic Sepsis</u>
PDX: P36.8 Other bacterial sepsis of newborn
SDX: D70 Agranulocytosis

<u>If the neonate has more than one infection</u>
Code sequence must align with the definition of a primary diagnosis.
Assign a specific code for the causative organism if known, for example, P36.0 Sepsis of newborn due to streptococcus, group B.

<u>If the source of the infection is related to a maternal condition, is not severe or life threatening and only lasts a few days</u>
PDX: P61.5 Transient neonatal neutropenia

Bacteraemia
Bacteremia refers to the presence of bacteria within the bloodstream. Clinical manifestations are typically mild if present. Bacteraemia can often be asymptomatic. Bacteria may enter the circulation through various routes, such as open wounds, invasive medical procedures, or even vigorous oral hygiene activities like brushing or flossing. Diagnosis is established through blood cultures, and appropriate antibiotic therapy is administered by healthcare professionals.

Urosepsis
Urosepsis is a serious and potentially life-threatening condition that occurs when a urinary tract infection (UTI) spreads into the bloodstream, triggering a systemic inflammatory response (sepsis).
Definition:
Urosepsis = Urinary Tract Infection (UTI) + Sepsis
It is usually caused by bacteria that originate in the bladder, ureters, kidneys, or prostate, and then enter the bloodstream.

Coding guidelines for sepsis:

1. Sepsis should **not automatically be assumed** as the primary diagnosis. Coders must carefully review the clinical documentation to determine whether sepsis was the main reason for admission or if another condition better meets the criteria for primary diagnosis.
- The code assigned in the **primary** position must meet the definition of a primary diagnosis.
- If the Coder is unable to determine the PDX, sequence the coding according to the clinician's documentation.

2. Where applicable, assign the infection code as the primary diagnosis, followed by additional codes for the causative organism and any drug-resistant agents.
- For drug resistant organisms, see code ranges: U82 (Resistance to betalactam antibiotics), U83 (Resistance to other antibiotics) and U84 (Resistance to other antimicrobial drugs).

3. If the ICD-10 code description already specifies the causative organism, assign only that specific code and do not add an additional code from categories B95–B98.
- For example:
  A41.3 Sepsis **due to Haemophilus influenzae**
  A22.7 **Anthrax** sepsis
  P23.2 Congenital pneumonia **due to Staphylococcus**

4. If the ICD-10 code description encompasses more than one organism, for example, A41.5 (Sepsis due to other Gram-negative organisms), then assign additional ICD-10 codes to specify the individual causative organisms, in addition to the primary code.
- For example: The patient presents with Gram-negative sepsis, with Escherichia coli and Pseudomonas species identified in the bloodstream.
  PDX: A41.5 Sepsis **due to other Gram-negative organisms**
  SDX: B96.2 **Escherichia coli [E. coli]** as the cause of diseases classified to other chapters
  SDX: B96.5 **Pseudomonas (aeruginosa)** as the cause of diseases classified to other chapters

5. Assign a code for sepsis when it is **clearly documented and confirmed by the treating doctor**, regardless of whether blood cultures are negative or inconclusive.
- A clinical diagnosis of sepsis may be based on presenting symptoms, even in the absence of positive blood cultures.
- Blood cultures may be **negative or unavailable** due to the following reasons:
  - Antibiotic therapy was initiated prior to blood culture collection, potentially affecting results.
  - Blood cultures were not available at the time of diagnosis.
  - Blood cultures were not requested by the treating doctor.
- In such cases, if the treating doctor has **documented and confirmed** the diagnosis of sepsis, the appropriate code should be assigned, regardless of blood culture findings.

6. Codes must **not** be assigned based solely on pathology results. A diagnosis must be **clearly documented and confirmed** by the treating doctor.

- Pathology reports may be used to:
  - Support the diagnosis when referenced in clinical documentation.
  - Identify the causative organism, which can be used to enhance coding specificity.
- Coders should ensure that the final diagnosis is clinically documented and not inferred from laboratory findings alone.

7. Systemic Inflammatory Response Syndrome (SIRS) must be coded in addition to the sepsis code.

- Codes from ICD-10 Category R65.- should never be assigned as the primary diagnosis.

8. Assign an additional code for organ failure only when documented by the treating doctor.

- Organ failure must not be assumed based solely on clinical indicators or laboratory results.
- ICD-10 does not provide a specific code to represent multiple organ failure. Therefore, coders must assign a separate code for each individual organ that has failed, as documented by the treating doctor.
- Confirm that the organ failure is directly related to the sepsis episode before assigning a code for organ failure.
- If the patient has a pre-existing chronic organ failure, ensure that the documentation clearly indicates an acute deterioration or new failure attributable to sepsis.

9. Septic shock must be coded in addition to the sepsis code.

- Septic shock should not be assigned as the primary diagnosis.

10. Assign a code for severe sepsis, R65.1 (Systemic Inflammatory Response Syndrome of infectious origin with organ failure), only when it is documented by the treating doctor, or when there is clear documentation of an associated acute organ dysfunction.

- If a patient has sepsis and an acute organ dysfunction, but the medical record indicates that the acute organ dysfunction is attributable to a condition other than sepsis, do not assign a code from subcategory R65.1 (Systemic Inflammatory Response Syndrome of infectious origin with organ failure).
- When severe sepsis is documented, coders must assign at least two codes, a code for the underlying systemic infection and R65.1 to indicate severe sepsis.
- If the causal organism is not specified in the medical record, assign code A41.9 (Sepsis, unspecified) for the infection.

11. When a patient is admitted with sepsis or severe sepsis and a localized infection such as pneumonia or cellulitis,

- Assign the localized infection code as a secondary diagnosis, unless:
  - The localized infection is clinically severe or life-threatening, or
  - It is the main condition treated during admission.
- If severe sepsis is documented, assign R65.1 as a secondary diagnosis.
- If the patient is admitted with a localized infection and sepsis or severe sepsis develops after admission,
  - Code the localized infection as the primary diagnosis, followed by the appropriate sepsis code, and R65.1 if severe sepsis is documented **provided the localized infection remains the clinically severe or life-threatening condition or the main condition treated**.

 **GSN**0001 **Primary Diagnosis**

Example:
A patient with a known history of HIV infection was admitted for Pneumocystis carinii pneumonia and subsequently developed sepsis during hospitalization.
* *As per the clinical record, main condition treated Pneumocystis carinii pneumonia*.

PDX: B20.6 (HIV disease resulting in Pneumocystis jirovecii pneumonia)
SDX: A41.9 (Sepsis, unspecified)

12. Code assignment for post-procedural complications should be based on the provider's documentation confirming a causal relationship between the infection and the procedure.

- For sepsis following a procedure, assign T81.4 (Infection following a procedure, not elsewhere classified) or O86.0 (Infection of obstetric surgical wound), as appropriate.
    - Assign an additional code for sepsis and include an additional code to identify the infectious agent.
    - If the patient presents with severe sepsis, assign R65.1 (Systemic Inflammatory Response Syndrome of infectious origin with organ failure) with the additional code(s) for any acute organ dysfunction.
- For infections following infusion, transfusion, therapeutic injection, or immunization, assign T80.2 (Infections following infusion, transfusion and therapeutic injection) or T88.0 (Infection following immunization), as applicable.
    - An additional code should be assigned to specify the type of infection.
- If a postprocedural infection has resulted in postprocedural septic shock, assign an additional code T81.1 (Shock during or resulting from a procedure, not elsewhere classified) with an additional code R57.2 (Septic shock).

  📖 Refer to point 9 above

13. In certain cases, a noninfectious condition such as trauma, burns, or other serious injuries may lead to an infection that progresses to sepsis or severe sepsis.

- If sepsis or severe sepsis is documented as being associated with a noninfectious condition, and that condition meets the criteria for primary diagnosis, the noninfectious condition should be sequenced first, followed by the code for the resulting infection.
- When severe sepsis is present, assign R65.1 (Systemic Inflammatory Response Syndrome of infectious origin with organ failure) with the additional code(s) for any acute organ dysfunction.

14. Systemic inflammatory response syndrome (SIRS) may arise from certain noninfectious disease processes, such as trauma, malignant neoplasms, or pancreatitis.

- When SIRS is documented in association with a noninfectious condition, and no subsequent infection is present, assign the code for the underlying condition (e.g., injury), followed by:
    - R65.2 (Systemic Inflammatory Response Syndrome of noninfectious origin without organ failure) or
    - R65.3 (Systemic Inflammatory Response Syndrome of noninfectious origin with organ failure), as appropriate.
- If acute organ dysfunction is documented, assign the relevant code(s) for the specific type of organ dysfunction in addition to R65.3.
- If organ dysfunction is present but it is unclear whether it is related to SIRS or another condition, such as trauma or another underlying cause, additional clarification should be requested from the treating provider.

15. When assigning a code from Chapter 15 for sepsis complicating abortion, pregnancy, childbirth, and the puerperium, an additional code should be assigned to specify the type of infection.

- Assign O85 (Puerperal sepsis) with an additional code from B95–B98 to identify the infectious agent.
- Assign O85 in conjunction with O86.0 (Infection of obstetric surgical wound) where appropriate.
- If severe sepsis is present, assign R65.1 (Systemic Inflammatory Response Syndrome of infectious origin with organ failure) with the additional code(s) for any acute organ dysfunction.

16. The category P36 (Bacterial sepsis of newborn) includes congenital sepsis.
- If a newborn is diagnosed with sepsis and there is no further documentation indicating whether it is congenital or community-acquired, the default assumption is congenital, and a code from category P36 should be assigned.
    - If the selected P36 code does not specify the causal organism, an additional code should be assigned to identify the infectious agent.
    - If severe sepsis is present, assign R65.1 (Systemic Inflammatory Response Syndrome of infectious origin with organ failure) with the additional code(s) for any acute organ dysfunction.

17. Assign D59.3 (Haemolytic-uraemic syndrome) for hemolytic uremic syndrome (HUS) associated with sepsis.
- Assign additional codes for the underlying systemic infection and any other conditions such as severe sepsis.

18. If the provider documents that the patient is a carrier, suspected carrier, or has colonization of Methicillin-resistant Staphylococcus aureus (MRSA) or Methicillin-susceptible Staphylococcus aureus (MSSA), assign Z22.3 (Carrier of other specified bacterial diseases).
- Both a carrier code Z22.3 and a code for the active MRSA infection, if present, may be assigned together, when supported by documentation.
- Where there is an active infection, assign an additional code from U82 Resistance to betalactam antibiotics, U83 Resistance to other antibiotics or U84 Resistance to other antimicrobial drugs to identify the drug to which the bacteria are resistant, when documented by the medical practitioner.

    📖 **DSN**0103 **Coding of infections with drug resistant micro-organisms**

19. When the site of infection is unknown, assign a code for infection of unspecified site by organism, followed by the appropriate code for sepsis.

20. If sepsis is documented but the code description does not explicitly include sepsis, and sepsis is referenced in the notes below the code, an additional code for sepsis should be assigned to accurately reflect the clinical condition.
An example is gonococcal sepsis

A54.8 Other gonococcal infections

Gonococcal:
- sepsis

PDX: A54.8 (Other gonococcal infections)
SDX: A41.9 (Sepsis, unspecified)

Scenario	Infectious	Non-Infectious	Without Organ Failure	With Organ Failure	Example
Non-infectious diseases with SIRS, without organ failure **PDX**: Other relevant non-infectious disease [excluding trauma and burns] **SDX**: R65.2 Systemic inflammatory response syndrome of non-infectious origin without organ failure		X	X		Patient diagnosed with non-infectious pancreatitis with systemic inflammatory response syndrome, due to alcoholism. **PDX**: K85.2 Alcohol-induced acute pancreatitis **SDX:** R65.2 Systemic inflammatory response syndrome of non-infectious origin without organ failure 📖 **DSN**0501 **Mental and behavioural disorders due to alcohol, drug and tobacco use** Assign **F10.-** where clinically appropriate.
Non-infectious disease with SIRS, with Organ failure **PDX:** Other relevant non-infectious disease [excluding trauma and burns] **SDX:** R65.3 Systemic inflammatory response syndrome of non-infectious origin with organ failure **SDX:** Organ failure		X		X	Patient with Crohn's disease develop a systemic response and acute kidney failure. **PDX:** K50.9 Crohn's disease, unspecified **SDX:** R65.3 Systemic inflammatory response syndrome of non-infectious origin with organ failure **SDX:** N17.9 Acute renal failure, unspecified
Infectious Sepsis/Septicaemia with SIRS, with culture positive results but no organ failure **PDX**: A40.- /A41.- [or other sepsis specific codes] **SDX**: R65.0 Systemic inflammatory response syndrome to infectious origin without organ failure **SDX:** Other relevant diseases [example pneumonia, influenza etc.] *For A41.8 - add a code from code range B95-B98 to indicate the causative organism	X			X	Patient developed septicaemia due to a Staphylococcus aureus. **PDX:** A41.0 Septicaemia due to a Staphylococcus aureus **SDX**: R65.0 Systemic Inflammatory Response Syndrome of infectious origin without organ failure
Infected burn or traumatic injury site, with positive culture results, without organ failure **PDX:** Burn or traumatic injury S /T code. **SDX:** Use the B95 - B98 code where relevant **SDX**: External Cause Code (ECC)	X		X		Patient with burn wounds on trunk [third degree]. Exposed to uncontrolled fire, in a building structure at work develops a Pseudomonas infection of the wounds. **PDX:** T21.3 Burn of third degree of trunk **SDX:** T31.- **SDX:** T79.3 Post-traumatic wound infection, not elsewhere classified **SDX:** B96.5 Pseudomonas (aeruginosa) as the cause of diseases classified to other chapters **SDX:** X00.62 Exposure to uncontrolled fire in building or structure, industrial and construction area, while working for income

Scenario	Infectious	Non-Infectious	Without Organ Failure	With Organ Failure	Example
Infectious Sepsis / Septicaemia with positive culture results SIRS with organ failure **PDX:** A40.- /A41.- [or other sepsis specific codes] **SDX:** R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure **SDX:** Organ failure code **SDX:** Other relevant disease / disorder codes *For A41.8 - add a code from code range B95-B98 to indicate the causative organism	X			X	Patient developed septicaemia due to a streptococcus, group A. And has a systemic response of acute renal failure. **PDX:** A40.0 Sepsis due to streptococcus, group A **SDX**: R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure **SDX:** N17.9 Acute renal failure, unspecified
Other infectious disease There are numerous other infectious and parasitic diseases listed within the ICD-10 classification. Apply the standard rule of coding Sepsis primary and include standards such as Dagger and Asterisk where relevant. **PDX**: Sepsis [e.g. Anthrax sepsis] **SDX:** R57.2 Septic shock if relevant **SDX**: R65.- SIRS Response **SDX:** Organ failure if relevant **SDX**: Other diseases / disorders	X		X		Patient with anthrax pneumonia, subsequently also develops a related septicaemia, septic shock and respiratory failure. **PDX:** A22.7 Anthrax sepsis **SDX**: R57.2 Septic Shock **SDX**: R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure **SDX:** J96.99 Respiratory failure, unspecified, Type unspecified **SDX:** A22.1+ Pulmonary anthrax **SDX:** J17.0* Pneumonia in bacterial diseases classified elsewhere

Scenario	PDX	SDX	Example
Localized medical infection, where cultures are available (e.g. Pneumonia, cellulitis)	**PDX:** Localized medical infection	**SDX:** Use the B95 - B98 code where relevant If not, add the causative organism separately, using a code from B95-B98	Patient with Cellulitis of leg. Culture came back positive for E-Coli **PDX:** L03.1 Cellulitis of other parts of limb **SDX:** B96.2 Escherichia coli [E. coli] as the cause of diseases classified to other chapters
Localized congenital/neonatal medical infections, where blood cultures are available e.g.: congenital pneumonia	**PDX:** Localized congenital/neonatal medical infection	**SDX:** Use the B95 - B98 code where relevant *If P23.8 - add a code for B95-B98 to indicate the causative organism	Neonate developed a congenital pneumonia due to a streptococcus A infection. **PDX:** P23.8 Congenital pneumonia due to other organisms **SDX:** B95.0 Streptococcus, group A, as the cause of diseases classified to other chapters
Localized wound infection (sepsis), Swab culture available with an abscess or stitch abscess	**PDX:** T81.4	**SDX:** Abscess/Stitch abscess **SDX:** Use the B95 - B98 code where relevant **SDX:** External Cause Code (ECC)	Patient treated for a stitch abscess following the removal of a lipoma on the shoulder. Infectious agent Pseudomonas (aeruginosa). **PDX:** T81.4 Infection following a procedure, not elsewhere classified **SDX:** L02.4 Cutaneous abscess, furuncle and carbuncle of limb **SDX:** B96.5 Pseudomonas (aeruginosa) as the cause of diseases classified to other chapters. **SDX:** Y83.8 Abnormal reaction/later complication, without mention of misadventure at the time of the procedure, other surgical procedures
Localized wound infection (sepsis), Swab culture available with an abscess or stitch abscess	**PDX:** T81.4	**SDX:** Abscess/Stitch abscess **SDX:** Use the B95 - B98 code where relevant **SDX:** External Cause Code (ECC)	Patient developed an intestinal abscess following a laparotomy a week ago. Infectious agent E.coli. **PDX:** T81.4 Infection following a procedure, not elsewhere classified **SDX:** K63.0 Abscess of intestine **SDX:** B96.2 Escherichia coli [E. coli] as the cause of diseases classified to other chapters **SDX:** Y83.8 Abnormal reaction/later complication, without mention of misadventure at the time of the procedure, other surgical procedures
Localised wound infection With a systemic sepsis Culture available • Establish the primary diagnosis and code according to what is most severe	**PDX:** T81.4 and A40.- A41.- or other relevant sepsis code	**SDX:** R65.- SIRS when relevant **SDX:** Organ failure if relevant **SDX:** S/T-code **SDX:** External Cause Code (ECC)	The patient developed a post-surgical wound infection with systemic sepsis due to anaerobic organisms, resulting in systemic inflammatory response syndrome with organ failure. **PDX:** T81.4 Infection following a procedure, not elsewhere classified **SDX:** A41.4 Sepsis due to anaerobes **SDX:** R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure **SDX:** Y83.8 Abnormal reaction/later complication, without mention of misadventure at the time of the procedure, other surgical procedures

Scenario	PDX	SDX	Example
Septic shock due to transfusion/lines etc.	**PDX**: T80.2	**SDX:** Use the B95 - B98 code to identify the organism **SDX:** Y60.1 / Y84.8 **SDX:** R57.2 Septic shock **SDX:** R65.0 SIRS when relevant **SDX:** Organ failure code/s if relevant *[if not related to sepsis, sequencing may differ and linked to the medical condition]	Patient was initially treated in ICU for congestive heart failure. The CVP line was replaced, and the tip of the previous line was sent to pathology. Results came back indicating this as the source of infection [Staphylococcus aureus as the cause of diseases classified to other chapters]. The patient developed septic shock. **PDX**: T80.2 Infections following infusion, transfusion and therapeutic injection **SDX:** B95.6 Staphylococcus aureus as the cause of diseases classified to other chapters **SDX:** Y84.8 Abnormal reaction/later complication, other medical procedures **SDX:** R57.2 Septic shock **SDX:** R65.0 Systemic Inflammatory Response Syndrome of infectious origin without organ failure **SDX:** I50.0 Congestive heart failure * If the main condition treated is the sepsis, then change the PDX according to Standard GSN0001.
Septicaemia post insertion of prosthetic device[s], Implants, grafts; and post-immunisation	**PDX:** Any of the following codes T82.6 / T82.7 / T83.5 / T83.6 / T84.5,6,7 / T85.7 / T88.0	**SDX:** ECC **SDX:** R65.- **SDX:** Organ failure **SDX:** Use the B95 - B98 code to identify the organism	Patient with a pacemaker for a bundle branch block developed septicaemia and SIRS which resulted in severe congestive heart failure. Organism: Coxsackievirus **PDX:** T82.7 Infection and inflammatory reaction due to cardiac and vascular devices, implants and grafts **SDX:** B97.1 Enterovirus as the cause of diseases classified to other chapters **SDX:** Y71.2 Cardiovascular devices associated with adverse incidents, prosthetic and other implants, materials and accessory devices **SDX:** R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure **SDX:** I50.0 Congestive heart failure
Septic shock post procedural	**PDX:** T81.1	**SDX:** Y60.- / Y83.- / Y84.- **SDX:** R57.2 Septic shock **SDX:** R65.0 SIRS when relevant **SDX:** Organ failure code/s if relevant *[if not related to sepsis, sequencing may differ and linked to the medical condition] **SDX:** Use the B95 - B98 code to identify the organism	Patient with cholecystitis went to theatre for a cholecystectomy, developed post cholecystectomy syndrome and septic shock post procedure. [Same admission] **PDX:** T81.1 Shock during or resulting from a procedure, not elsewhere classified **SDX:** Y83.8 Abnormal reaction/later complication, without mention of misadventure at the time of the procedure, other surgical procedures **SDX:** R57.2 Septic shock **SDX:** K91.5 Post cholecystectomy syndrome **SDX:** K81.9 Cholecystitis, unspecified

Scenario		PDX	SDX	Example
Sepsis/Septic shock associated with abortion	**Acute**	**PDX:** code according to the abortion table: assign a code from code range O03.-to O07.- - For *incomplete abortion complicated by genital tract and pelvic infection* - See codes O03.0; O04.0; O05.0; O06.0; O07.0 - For *incomplete abortion complicated by embolism* (septic or septicopyaemic) O03.2; O04.2; O05.2; O06.2; O07.2 - For *complete or unspecified abortion complicated by genital tract and pelvic infection*: see codes O03.5, O04.5, O05.5, O06.5, O07.5 - For *complete or unspecified abortion complicated by embolism* (septic or septicopyaemic): see codes: O03.7, O04.7, O05.7, O06.7, O07.7	**SDX:** R57.2 Septic shock **SDX:** Use the B95 - B98 code where relevant	Patient admitted with genital tract infection due to a spontaneous incomplete abortion. She developed septic shock and E-Coli was isolated **PDX:** OO3.0 Spontaneous abortion, incomplete, complicated by genital tract and pelvic infection **SDX:** R57.2 Septic shock **SDX:** B96.2 Escherichia coli [E. coli] as the cause of diseases classified to other chapters
	Subsequent	**PDX:** O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy or **PDX:** O08.2 Embolism following abortion and ectopic and molar pregnancy * Also use for septic or septicopyaemic embolism		Patient admitted with septic shock, genital tract and pelvic infection, subsequent to an incomplete Illegal abortion performed a week ago. E-Coli isolated **PDX:** O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy **SDX:** R57.2 Septic shock **SDX:** B96.2 Escherichia coli [E. coli] as the cause of diseases classified to other chapters
	For both acute and subsequent abortion scenarios	**PDX:** O codes from O03.- to O07.- Do not add A40.- and A41.- additionally to the O codes from O03.- to O07.-	**SDX:** R57.2 Septic shock **SDX:** R65.- code when relevant **SDX:** Use the additional B95 - B98 code to identify the infectious organism **SDX:** organ failure, if relevant	The patient had an incomplete abortion complicated by septic embolism which progressed to septic shock, respiratory failure, and systemic inflammatory response syndrome. The causative organism identified was Klebsiella pneumoniae. **PDX:** O06.2 Unspecified abortion, incomplete, complicated by embolism **SDX:** O06.0 Unspecified abortion, incomplete, complicated by genital tract and pelvic infection **SDX:** R57.2 Septic shock **SDX:** B96.1 Klebsiella pneumoniae [K. pneumoniae] as the cause of diseases classified to other chapters **SDX:** R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure **SDX:** O99.5 Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium **SDX:** J96.99 Respiratory failure, unspecified, Type unspecified

Scenario		PDX	SDX	Example
Sepsis/Septic shock associated with abortion	**For both acute and subsequent abortion scenarios**	**PDX:** O codes from O03.- to O07.- Do not add A40.- and A41.- additionally to the O codes from O03.- to O07.-	**SDX:** R57.2 Septic shock **SDX:** R65.- code when relevant **SDX:** Use the additional B95 - B98 code to identify the infectious organism **SDX:** organ failure, if relevant	**For a subsequent admission:** Patient admitted following an incomplete abortion. Complicated by septic embolism. She also developed septic shock and respiratory failure. Organism: Klebsiella pneumoniae **PDX:** O08.2 Embolism following abortion and ectopic and molar pregnancy **SDX:** O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy **SDX:** R57.2 Septic shock **SDX:** R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure **SDX:** B96.1 Klebsiella pneumoniae [K. pneumoniae] as the cause of diseases classified to other chapters **SDX:** O99.5 Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium **SDX:** J96.99 Respiratory failure, unspecified, Type unspecified

Scenario		PDX	SDX	Example
Maternity sepsis	**Puerperal Sepsis**	**PDX:** O85 Do not add A40.- and A41.-	**SDX:** R65.- SIRS when relevant **SDX:** Use the additional B95 - B98 code to identify the infectious organism **SDX:** Organ failure, if relevant **SDX:** Other relevant maternity coding	Patient admitted 3 weeks after a delivery, she developed puerperal sepsis, E-coli found in blood. She has a systemic response of acute renal failure. **PDX:** O85 Puerperal sepsis **SDX:** R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure **SDX:** B96.2 Escherichia coli [E. coli] as the cause of diseases classified to other chapters **SDX:** N17.9 Acute renal failure, unspecified
	Obstetric pyaemic and septic embolism	**PDX:** O88.3 Obstetric pyaemic and septic embolism *Look out for other obstetric embolism codes such as O88.1 Amniotic fluid embolism etc. Do not add A40.- and A41.-	**SDX:** R65.- SIRS when relevant **SDX:** O98.- to identify the infectious and parasitic disease **SDX:** Use the additional B95 - B98 code to identify the infectious organism **SDX:** Organ failure if relevant **SDX:** Other relevant maternity coding	Patient that had a spontaneous vertex delivery, developed a septic amniotic fluid embolism. She went into respiratory failure and is ventilated in ICU. Outcome of delivery: live born infant **PDX:** O88.1 Amniotic fluid embolism **SDX:** R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure **SDX:** O99.5 Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium **SDX:** J96.99 Respiratory failure, unspecified, Type unspecified **SDX:** O80.0 Spontaneous vertex delivery **SDX:** Z37.0 Single live birth **SDX:** Z99.1 Dependence on respirator
	Maternal wound sepsis	**PDX:** O86.0 Infection of obstetric surgical wound Do not add A40.- and A41.-	**SDX:** R65.- SIRS when relevant **SDX:**: Use the additional B95 - B98 code to identify the infectious organism **SDX:** Organ failure if relevant **SDX:** Other relevant maternity coding	Patient had a vaginal delivery with an episiotomy 3 weeks ago. She developed wound sepsis to the episiotomy incision and an pseudomonas was identified. While in hospital for treatment she developed acute renal failure **PDX:** O86.0 Infection of obstetric surgical wound **SDX:** R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure **SDX:** B96.5 Pseudomonas (aeruginosa) as the cause of diseases classified to other chapters **SDX:** N17.9 Acute renal failure, unspecified ** Coding sequencing could differ depending on the main condition treated
	Sepsis during labour	**PDX:** O75.3 Other infection during labour [sepsis during labour] *Look out for other medical conditions such as - premature rupture of membranes, foetal death etc.	**SDX:** R65.- SIRS when relevant **SDX:** O98.- to identify the infectious and parasitic disease **SDX:** Use the additional B95 - B98 code to identify the infectious organism **SDX:** Organ failure if relevant **SDX:** Other relevant maternity coding	Patient with a gonorrhoea infection, went into prolonged first stage labour. While in labour it became evident that she has pyrexia. Blood results indicate in retrospect that it was caused by the gonorrhoeal infection. She had a vacuum extraction of a liveborn baby. **PDX:** O75.3 Other infection during labour [sepsis during labour] **SDX:** *O98.2 Gonorrhoea complicating pregnancy, childbirth and the puerperium **SDX:** O63.0 Prolonged first stage labour (of labour) SDX: O81.4 Vacuum extractor delivery **SDX:** Z37.0 Single live birth * Organism bundled into code O98.2 and not coded separately

Scenario	PDX	SDX	Example
Neonatal (newborn) Sepsis	**PDX:** P36.- Bacterial sepsis of newborn [various options available for different organisms] Do not assign A40.- and A41.-	**SDX:** R65.- SIRS if relevant **SDX:** Organ failure if relevant **SDX:** Other neonatal codes *If P36.8 - add a code for B95-B98 to indicate the causative organism	Premature baby [32 weeks - birth weight 1800 grams] developed primary atelectasis shortly after birth. Under water drain inserted and pleural fluid indicate the presence of a Staphylococcus aureus sepsis. **PDX:** P36.2 Sepsis of newborn due to Staphylococcus aureus **SDX:** P28.0 Primary atelectasis of newborn **SDX:** P07.1 Other low birth weight **SDX:** P07.3 Other preterm infants **SDX:** Z38.0 Singleton, born in hospital
Urosepsis If a patient develops sepsis due to a UTI then assign a sepsis code from A40.- or A41.- and the causative organism from code range B95-B98, where appropriate. Sequencing will depend on what is most severe. The same will apply to genitourinary tract infection during pregnancy, labour and delivery. Applicable to O23.- Infections of genitourinary tract in pregnancy and O86.2 Urinary tract infection following delivery	**PDX:** N39.0 / O23.- / O86.2	**SDX:** A40.- or A41.- **SDX:** B95-B98 Infectious organism	The pregnant patient was diagnosed with urosepsis originating from a kidney infection and commenced on antibiotic therapy. Blood and urine cultures were positive for coagulase-negative *Staphylococcus*. Due to the systemic infection, the doctor identified the patient as high risk for potential abortion. **PDX:** O98.8 Other maternal infectious and parasitic diseases complicating pregnancy, childbirth and the puerperium **SDX:** O23.0 Infections of kidney in pregnancy **SDX:** B95.7 Other staphylococcus as the cause of diseases classified to other chapters **SDX:** A41.1 Sepsis due to other specified staphylococcus **SDX:** Z35.8 Supervision of other high-risk pregnancies *Z35.8 would be optional*
Other infectious disease There are numerous other infectious and parasitic diseases listed within the ICD-10 classification. Apply the standard rule of coding Sepsis primary, and include standards such as Dagger and Asterisk where relevant	**PDX:** Organism	**SDX:** Manifest	Patient with anthrax pneumonia, subsequently also develops a related septicaemia, septic shock and respiratory failure. **PDX:** A22.7 Anthrax sepsis **SDX:** R57.2 Septic shock **SDX:** R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure **SDX:** J96.99 Respiratory failure unspecified, Type unspecified **SDX:** A22.1 + Pulmonary anthrax **SDX:** J17.0* Pneumonia in bacterial diseases classified elsewhere

PHISC Addendum to the South African ICD-10 Morbidity Coding Standards and Guidelines document

PHISC amendment to DSN0105 Coding diarrhoea and gastroenteritis without further specification

🕮 **DSN**0105 **Coding diarrhoea and gastroenteritis without further specification**

Diarrhoea and gastroenteritis should be assumed to be infectious in origin and coded to **A09.0 Other and unspecified gastroenteritis and colitis of infectious origin** until otherwise stated.

If the medical record indicates that the patient had both gastroenteritis and vomiting, then **A09.0 Other and unspecified gastroenteritis and colitis of infectious origin** should be assigned.

- *Gastroenteritis typically involves both diarrhoea and vomiting*

If the medical record indicates that the patient had both diarrhoea and vomiting, then **A09.0 Other and unspecified gastroenteritis and colitis of infectious origin** and **R11 Nausea and vomiting** should be assigned. The reason for this is to keep the record of the vomiting until the cause of the diarrhoea has been established.

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

PCS02 Neoplasms (C00 – D48)

PCS0201 **Neoplasm Coding**

🕮 **DSN**0201 **Neoplasm Coding**

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

PHISC addition to “Ca” guideline:
Clinical Coders should make every effort to identify the detailed morphological description and the default code should only be assigned as the last resort.

PHISC change to guideline
Second sentence removed from the guideline
Z51.2 Other chemotherapy should be assigned when chemotherapy is administered for treatment of non-cancer diagnoses e.g. for the treatment of auto-immune conditions.

Histopathology report vs ICD-10 and morphology codes assigned by the treating doctor
Codes to be assigned as recorded by the Histopathologist.

Sequencing of Neoplasm, Morphology, Dagger and Asterisk Codes
Assign codes as follows:

Example:
Patient for treatment of collapsed lumbar vertebra due to secondary malignant neoplasm of the bone.

PDX: C79.5 Secondary malignant neoplasm of bone and bone marrow
SDX: M8000/6 Neoplasm, malignant, metastatic site
SDX: C79.5+ Secondary malignant neoplasm of bone and bone marrow
SDX: M49.56* Collapsed vertebra in diseases classified elsewhere, lumbar region

🕮 **DSN**0201 **Neoplasm Coding**

Morphology codes

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

If morphology codes are assigned, they must be valid on the ICD-10 Master Industry Table (MIT) as they are subject to secondary code validation and rejection.

PHISC amendment to C80

PHISC amendment related to code C80, as referenced in the example provided in the South African ICD-10 Coding Standards and Guidelines document.
C80 is no longer a valid three-character code.

Guidelines for coding "Metastatic Cancer"

"Metastatic from"
Cancer described as "metastatic from" a site should be interpreted as primary of the stated site. Also assign the code for the secondary neoplasm of the specified site (if the secondary site is identified), or for the secondary malignant neoplasm of unspecified site (if the secondary site is not identified).

Example: Metastatic spread from the breast
PDX: C50.9 Malignant neoplasm, breast, unspecified
SDX: M8000/3 Neoplasm, malignant, primary site
SDX: C79.9 Secondary malignant neoplasm, unspecified site
SDX: M8000/6 Neoplasm, malignant, metastatic site

PHISC amendment to the guideline for coding anaemia associated with malignant blood disorders

Assign an additional code for anaemia when it occurs in association with malignant blood disorders, such as leukaemia

Anaemia due to malignant blood disorders

Example:
Admission for anaemia in myelodysplasia.

PDX: D46.9 Myelodysplastic syndrome, unspecified
SDX: M9989/3 (Myelodysplastic syndrome, NOS)
SDX: D46.9+ Myelodysplastic syndrome, unspecified
SDX: D63.0* Anaemia in neoplastic disease (C00-D48+)

Anaemia caused by chemotherapy

Example:
Patient receiving chemotherapy for acute myeloid leukaemia (AML), developed severe anaemia directly attributed to the chemotherapy agent.

PDX: C92.0 Acute myeloblastic leukaemia [AML]
SDX: M9872/3 Acute myeloid leukaemia, minimal differentiation
SDX: D64.9 Anaemia, unspecified
or if it was mentioned as "drug-induced folate deficiency anaemia" then, D52.1 Drug-induced folate deficiency anaemia
SDX: Y43.3 Adverse effects in therapeutic use, other antineoplastic drugs
SDX: Z51.1 Chemotherapy session for neoplasm

- Assign Z51.1 when chemotherapy is administered during the same episode of care.
- For primary diagnosis refer to GSN0001 Primary Diagnosis

Anaemia caused by poor dietary intake
Example:

Patient admitted for blood transfusion due to iron-deficiency anaemia due to poor dietary intake. Patient has acute myeloid leukaemia.
PDX: D50.8 Other iron deficiency anaemias
SDX: C92.0 Acute myeloblastic leukaemia [AML]
SDX: M9872/3 Acute myeloid leukaemia, minimal differentiation

Anaemia due to blood loss from an injury in a patient with a malignant blood disorder
Assign a code the open wound or injury as the primary diagnosis, followed by codes for the anaemia and leukaemia, with no assumed causal relationship between the anaemia and leukaemia.

Example:
The patient developed post-haemorrhagic anaemia following an injury and has a known history of leukaemia.
PDX: S or T code
SDX: D50.0 Iron deficiency anaemia secondary to blood loss (chronic) **or**
D62 Acute posthaemorrhagic anaemia (*if documented as acute*)
SDX: External cause code (ECC)
SDX: Leukaemia
SDX: Morphology code

PCS03 Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50 – D89)

Coding of diagnosis if indicated as "patient is immunocompromised"

Obtain detailed information and assign an ICD-10 code based on the information available. Follow the alphabetical index.
Lead term:
Immune compromised NEC D89.9
Immunodeficiency D84.9

PCS04 Endocrine, nutritional and metabolic diseases (E00 – E90)

Coding of male androgen excess
Assign E34.8 and codes for presenting symptoms.

Example 1:

34-year-old male patient presenting with enlarged prostate, decreased testicular size, erectile dysfunction and gynecomastia. Following investigation, he was diagnosed with androgen excess.

PDX: E34.8 Other specified endocrine disorders
SDX: N40 Hyperplasia of prostate
SDX: N50.0 Atrophy of testis
SDX: N48.4 Impotence of organic origin
SDX: N62 Hypertrophy of breast
SDX: R86.1 Abnormal findings in specimens from male genital organs, abnormal level of hormones

Refer to DSN18 and PCS18 (Guidelines when using sign and symptom codes).

Necrobiosis Lipoidica in Diabetes

Assign L92.1 (Necrobiosis lipoidica, not elsewhere classified) in addition to the dagger and asterisk code.

As per the alphabetical index.
Necrobiosis
– lipoidica
– – with diabetes (see also E10 – E14 with fourth character .6) E14.6+L99.8*

Example:
Female diabetic patient diagnosed with Necrobiosis lipoidica.

PDX: E10+ – E14+ with fourth character .6
SDX: L99.8* Other specified disorders of skin and subcutaneous tissue in diseases classified elsewhere
SDX: L92.1 Necrobiosis lipoidica, not elsewhere classified

Hyperglycaemia and Hypoglycaemia in Diabetes

📖 **DSN18 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99), Guidelines when using sign and symptom codes** and **PHISC additions to guideline**.

When the reason for admission is to stabilize poorly controlled diabetes, assign R73.9 (Hyperglycemia, unspecified) or E16.2 (Hypoglycemia, unspecified) in addition to the diabetes code from categories E10.- to E14.- with a fourth character of **.6 "with other specified complications"**.

Example 1:
A known type I diabetic patient is admitted for the stabilization of elevated Haemoglucotest (HGT).

PDX: E10.6 Type 1 diabetes mellitus with other specified complications
SDX: R73.9 Hyperglycaemia, unspecified

Example 2:
An adult-onset Type II diabetic patient is admitted for the treatment of persistent hypoglycaemia

PDX: E11.6 Type 2 diabetes mellitus with other specified complications
SDX: E16.2 Hypoglycaemia, unspecified

Code for Catabolysis
Assign E88.8 (Other specified metabolic disorders) for catabolysis.

Example 1:
A female patient was admitted via the emergency unit, presenting with catabolysis.

PDX: E88.8 (Other specified metabolic disorders)

Example 2:
A female patient was admitted via the emergency unit, presenting with catabolysis. She had been missing for four days and was found unconscious in a field near her residence. No physical injuries were noted upon admission.

PDX: E88.8 (Other specified metabolic disorders)
SDX: R40.2 (Coma, unspecified)

PCS05 Mental and behavioural disorders (F00-F99)

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

Example 3:
75-year-old patient admitted with smoking related chronic obstructive pulmonary disease (COPD). Notes indicate that he has been unsuccessful in his attempts to quit.

PDX: J44.9 Chronic obstructive pulmonary disease, unspecified
SDX: F17.1 Mental and behavioural disorders due to use of tobacco, harmful use

PHISC Note:
If the patient is admitted with chronic obstructive pulmonary disease (COPD) and it is mentioned in the patient's record that he is a smoker, and there is no mention of harmful use or dependence, assign Z72.0 (Tobacco use).

Example 6:
75-year-old patient admitted with chronic obstructive pulmonary disease (COPD). Patient smokes cigarettes as per his medical record.

PDX: J44.9 Chronic obstructive pulmonary disease, unspecified
SDX: Z72.0 Tobacco use

PHISC Guideline for coding a mild depressive episode

Assign a code for the mild depressive episode based on the recorded diagnosis. Take note of the inclusion and exclusion notes below F32 (Depressive episode) and F33 (Recurrent depressive disorder) when assigning a code for mild depressive episode.

PHISC Guideline for coding Neurocognitive Disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has replaced the term "dementia" with "major and mild neurocognitive disorders" (NCDs). This was done in an effort to reduce the stigma attached to the term dementia. However, many clinicians and organisations will likely continue to use the term dementia as their patients are accustomed to it.

Assign F06.7 (Mild cognitive disorder) for mild neurocognitive disorder and F03 (Unspecified dementia) for major neurocognitive disorder.

PCS06 Diseases of the nervous system (G00 – G99)

PHISC Guideline for coding of Dravet Syndrome

What Is Dravet Syndrome?
Dravet syndrome, previously known as severe myoclonic epilepsy of infancy (SMEI), is a rare and serious type of epilepsy. The first seizure often happens with a high fever and can last more than five minutes. It can lead to developmental delays, trouble with speech and language, and problems with balance or walking.
Long seizures can be dangerous, so care plans often include steps to stay safe and prepare for emergencies[3].

Assign G40.8 (Other epilepsy) for Dravet syndrome. Where documented, assign additional codes to identify associated manifestations or the severity of the condition. For example, assign R40.1 (Stupor) when stupor is present and documented.

[3] Dravet Syndrome: What It Is, Symptoms, Treatment & Prognosis (accessed 12/05/2026)

PCS09 Diseases of the circulatory system (I00 – I99)

PCS0901 **Coding of the Circulatory System (I00 – I99)**

DSN0901 **Coding of the Circulatory System**

Hypertension and renal disease or conditions

Rule:
For hypertension and renal disease or renal failure, only presume a link or causal relationship between the two conditions if it is clearly stated by the physician that the renal disease is due to the hypertension. Phrases such as hypertensive and due to hypertension indicate a causal relation.

Table 1[4]

Instruction	Tabular list entries
Revise inclusion: (January 2010)	**I12** **Hypertensive renal disease** ***Includes:*** any condition in N18.-, N19, or N26 ~~with any condition in I10~~ due to hypertension arteriosclerosis of kidney arteriosclerotic nephritis (chronic)(interstitial) hypertensive nephropathy nephrosclerosis ***Excludes:*** secondary hypertension (I15.-) **I12.0** **Hypertensive renal disease with renal failure** Hypertensive renal failure **I12.9** **Hypertensive renal disease without renal failure** Hypertensive renal disease NOS

Guideline for coding of hypertensive crisis
I10 Essential (primary) hypertension must be assigned as there is no other code for hypertensive crisis.

I10 includes
Hypertension
(arterial)(benign)(essential)(malignant)(primary)(systemic)

[4] WHO Corrigenda, Official WHO Updates combined 1996 2015 VOLUME 1

Coding of ST-Elevation Myocardial Infarction (STEMI) and non-ST segment elevation myocardial infarction (NSTEMI)

Non-ST segment elevation myocardial infarction (NSTEMI)
Refer to the ICD-10 Alphabetical Index (volume 3), Fifth edition, 2016.
Infarct, infarction (of)
– myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
– – non-ST elevation (NSTEMI) **I21.4**

Refer to the ICD-10 Tabular List (volume 1), Fifth edition, 2016.
I21.4 Acute subendocardial myocardial infarction
Myocardial infarction with non-ST elevation

ST segment elevation myocardial infarction (STEMI)
Assign a code from I21.0 – I21.3.

Assign a code from I22.0 – I22.9 for subsequent ST segment elevation myocardial infarction (STEMI) and subsequent non-ST segment elevation myocardial infarction (NSTEMI).

Guideline for coding a pleural effusion due to cardiac failure

 Refer to guidelines when using sign and symptom codes e.g. R-codes

Pleural effusions are common in patients with congestive heart failure.
Assign J91* (Pleural effusion in conditions classified elsewhere) where there is distinct treatment such as a chest drain. Additional coding is not required if there is no distinct treatment of the pleural effusion as a result of the congestive heart failure.

Example 1:
65-year old patient admitted for treatment of a pleural effusion due to congestive heart failure. Patient had a chest X-ray and a CT scan. For further management.

PDX: I50.0+ Congestive heart failure
SDX: J91* Pleural effusion in conditions classified elsewhere

Example 2:
65-year old patient admitted for treatment of a pleural effusion due to congestive heart failure. Patient know to have hypertensive heart disease with congestive heart failure.

PDX: I11.0+ Hypertensive heart disease with (congestive) heart failure
SDX: J91* Pleural effusion in conditions classified elsewhere

PCS10 Diseases of the respiratory system (J00 – J99)

DSN10 Diseases of the respiratory system (J00 – J99)

PHISC Guideline for the coding of Respiratory Distress

Neonate within 28 days
Premature newborn admitted with respiratory distress following delivery in hospital.
PDX: P22.9 Respiratory distress of newborn, unspecified
SDX: P07.3 Other preterm infants
SDX: Z38.0 Singleton, born in hospital

Premature newborn admitted with respiratory distress syndrome following delivery in hospital.
PDX: P22.0 Respiratory distress syndrome of newborn
SDX: P07.3 Other preterm infants
SDX: Z38.0 Singleton, born in hospital

Neonate readmitted after 28 days linked to perinatal period
Six week old baby re-admitted with respiratory distress.
PDX: P22.9 Respiratory distress of newborn, unspecified

Six week old baby re-admitted with respiratory distress syndrome.
PDX: P22.0 Respiratory distress syndrome of newborn

First time after 28 days
Six week old baby admitted with respiratory distress.
PDX: R06.0 Dyspnoea

Six week old baby admitted with respiratory distress syndrome.
PDX: J80 Adult respiratory distress syndrome

Two year old child admitted with respiratory distress syndrome.
PDX: J80 Adult respiratory distress syndrome

Vaping Related Disorder

Please take note of the following as per information received from the World Health Organisation (WHO) through the South African Medical Research Council (MRC), the designated WHO-FIC collaborating centre for the African Region, on 24 September 2019.

In reaction to the recent occurrence of vaping related disorder, and in consultation with the WHO Framework convention on Tobacco control, the WHO-FIC Network CSAC was convened to discuss a code for vaping related illness for immediate use.

Vaping related disorder is coded in ICD-10 with U07.0, (and in ICD-11 with RA00.0). The code is valid for use as of today.

In response to this and based on the inputs received from members of the PHISC ICD-10 Technical work group, the following recommendations have been made for assigning the ICD-10 code U07.0 for **Vaping Related Disorder**:

U07.0 is an active and valid code for use on our South African ICD-10 Master Industry Table (MIT).
As per the ICD-10 2019 version, use additional code, if desired, to identify pneumonia or other manifestations.

* *Please reference GSN0001 from the South African ICD-10 Morbidity Coding Standards and Guidelines document when selecting the primary diagnosis.*

Example 1:
Patient presented with coughing, chest pain and shortness of breath established to be due to vaping.

* PDX: U07.0 Vaping-related disorder
SDX: R05 Cough
SDX: R07.4 Chest pain, unspecified
SDX: R06.0 Dyspnoea

Example 2:
Patient diagnosed with bronchitis established to be due to vaping.

* PDX: U07.0 Vaping-related disorder
SDX: J68.0 Bronchitis and pneumonitis due to chemicals, gases, fumes and vapours

Example 3:
Patient admitted with acute respiratory distress syndrome due to vaping.

* PDX: J80 Adult respiratory distress syndrome
SDX: U07.0 Vaping-related disorder

Example 4:
Patient admitted with acute respiratory failure and chest infection. Known to have a vaping related disorder. Sputum results indicate the presence of a Staphylococcus Aureus as the cause of infection.

* PDX: J96.09 Acute respiratory failure, Type unspecified
SDX: J22 Unspecified acute lower respiratory infection
SDX: B95.6 *Staphylococcus aureus* as the cause of diseases classified to other chapters
SDX: U07.0 Vaping-related disorder

Reference: PHISC Communication (Vaping Related Disorder U07.0 18/05/2020)

PHISC
Private Healthcare Information Standards Committee
PHISC Trust: IT2091/2012
Email: phisc.secretariat@gmail.com
Website: www.phisc.net

07/04/2020

Dear PHISC members,

URGENT COMMUNICATION REGARDING THE CLINICAL CODING OF

NOVEL CORONAVIRUS: COVID-19

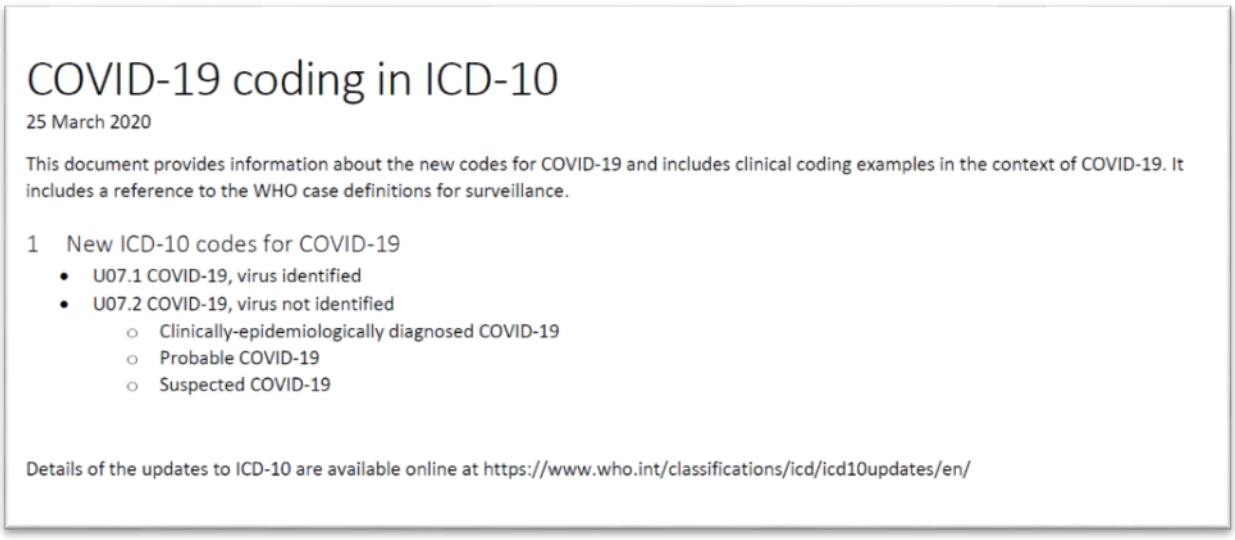
COMMUNICATION 3

Based on information received from the Medical Research Council (MRC), designated as the WHO-FIC Collaborating Center for the Africa Region, and reported media releases from the World Health Organisation (WHO) on 25th March 2020. Please familiarise yourself with the content below. PHISC suggest that these guidelines are strictly followed.

Communication about the use of U07.1 Emergency code to be used for Corona virus was sent to all on 13/02/2020. Further to this the WHO also authorised the use of U07.2. For more detail about when to use U07.2, please see information below

ICD_Code	WHO_Full_Desc	Valid_ICD10_Clinical use	Valid_ICD10_Primary
U07.1	Emergency use of U07.1	Y	Y
U07.2	Emergency use of U07.2	Y	Y

Please follow the coding guidelines as communicated by the WHO below:



COVID-19 coding in ICD-10

25 March 2020

This document provides information about the new codes for COVID-19 and includes clinical coding examples in the context of COVID-19. It includes a reference to the WHO case definitions for surveillance.

1 New ICD-10 codes for COVID-19

- U07.1 COVID-19, virus identified
- U07.2 COVID-19, virus not identified
  - Clinically-epidemiologically diagnosed COVID-19
  - Probable COVID-19
  - Suspected COVID-19

Details of the updates to ICD-10 are available online at https://www.who.int/classifications/icd/icd10updates/en/

2 Clinical Coding of COVID-19 with ICD-10

	No symptoms	With symptoms	ICD-10 codes
Confirmed cases	Positive test result only, patient showing no symptoms		U07.1
	Positive test result	COVID-19 documented as cause of death	U07.1*
	Positive test result	Use additional code(s) for respiratory disease (e.g. viral pneumonia J12.8) or signs or symptoms of respiratory disease (e.g. shortness of breath R06.0, cough R05) as documented	U07.1 + codes for symptoms *

*Use intervention/procedure codes to capture any mechanical ventilation or extracorporeal membrane oxygenation and identify any admission to intensive care unit

*Use additional codes for isolation (Z29.0) or laboratory examination (Z01.7) as required for the specific case

	Patient presents with acute respiratory illness	Contact or suspected exposure	ICD-10 codes
Suspected/probable cases	No other etiology; history of travel	√	U07.2; Z20.8 + codes for symptoms*
	Contact with confirmed or probable case	√	U07.2; Z20.8 + codes for symptoms*
	No other etiology: hospitalization required		U07.2 + codes for symptoms*
	COVID-19 documented without any further information re: testing		U07.2 + codes for any symptoms*

*Use intervention/procedure codes to capture any mechanical ventilation or extracorporeal membrane oxygenation and identify any admission to intensive care unit

*Use additional codes for isolation (Z29.0) or laboratory examination (Z01.7) as required for the specific case

	Presenting clinical scenario	ICD-10 codes
COVID-19 ruled out	Patient presents with acute respiratory illness; testing is negative, and COVID-19 is ruled out	Code the relevant stated infection/diagnosis + Z03.8 *Observation for other suspected diseases and conditions*
	Self-referral: after assessment no reason to suspect disease and further investigations deemed unnecessary	Code Z71.1 *Person with feared complaint in whom no diagnosis is made*

Testing for COVID-19	Based on clinical judgement, clinicians may order a test for the SARS-CoV-2 virus in a patient who does not strictly meet the case definition.	Code Z11.5 *Special screening examination for other viral diseases*

3 Mortality Coding of COVID-19 with ICD-10

Both categories, U07.1 (COVID19, virus identified) and U07.2 (COVID19, virus not identified) are suitable for cause of death coding. Similarly, new codes were created for ICD-11.

COVID-19 is reported on a death certificate as any other cause of death, and rules for selection of the single underlying cause are the same as for influenza (COVID-19 not due to anything else).

For recording on a death certificate, no special guidance needs to be given. The respiratory infection may evolve to pneumonia that may evolve to respiratory failure and other consequences. Potentially contributing comorbidity (immune system problem, chronic diseases...) is reported in part 2, and other aspects (perinatal, maternal...) in frame B, in line with the rules for recording.

A manual plausibility check is recommended for certificates where COVID-19 is reported, in particular for certificates where COVID-19 was reported but not selected as the single underlying cause of death.

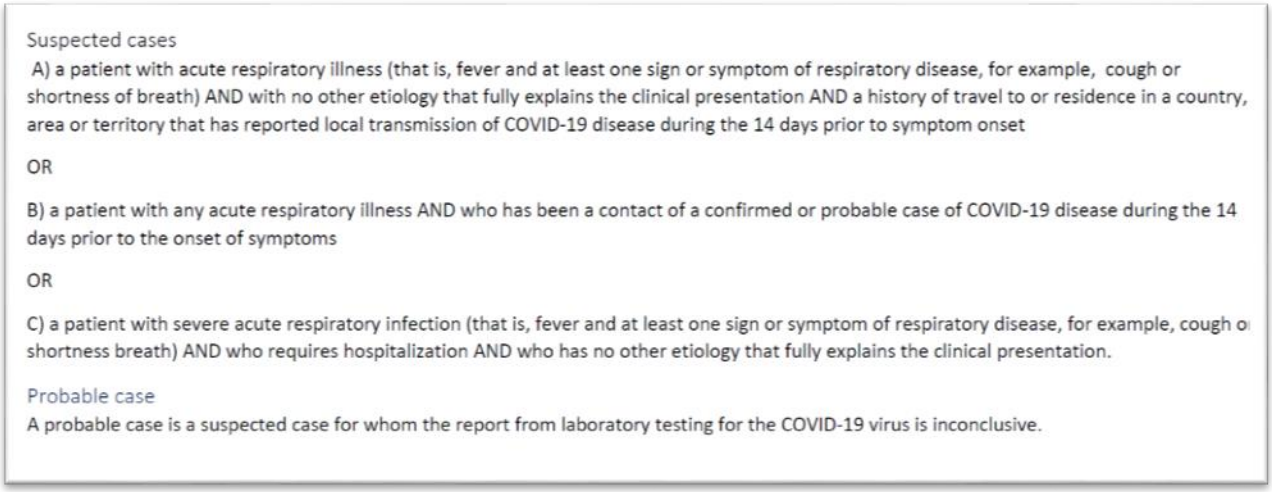


4 WHO COVID-19 Case definitions for Global Surveillance[1] 24 March 2020

Confirmed cases

A confirmed case is a person with laboratory confirmation of infection with the COVID-19 virus, irrespective of clinical signs and symptoms.

[1] https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov)



Suspected cases

A) a patient with acute respiratory illness (that is, fever and at least one sign or symptom of respiratory disease, for example, cough or shortness of breath) AND with no other etiology that fully explains the clinical presentation AND a history of travel to or residence in a country, area or territory that has reported local transmission of COVID-19 disease during the 14 days prior to symptom onset

OR

B) a patient with any acute respiratory illness AND who has been a contact of a confirmed or probable case of COVID-19 disease during the 14 days prior to the onset of symptoms

OR

C) a patient with severe acute respiratory infection (that is, fever and at least one sign or symptom of respiratory disease, for example, cough o shortness breath) AND who requires hospitalization AND who has no other etiology that fully explains the clinical presentation.

Probable case

A probable case is a suspected case for whom the report from laboratory testing for the COVID-19 virus is inconclusive.

The existing ICD-10 sequencing guidelines contained in the SA ICD-10 Morbidity Coding Standards and Guidelines documents should still be adhered to, hence the U07.1 and U07.2 codes can be used in either the primary or secondary coding position(s), as relevant to the main condition treated.

System software updates:

While the ICD-10 Master Industry Table (MIT) descriptions will continue to be as per the column above on the NDoH website, we suggest that all internal software is updated to be in line with the updated descriptions for U07.1 and U07.2 as provided by MRC and WHO.

The description of ICD-10 coding is not sent out electronically, and it should therefore not impact on any accounts sent and / or received, but will allow the user to be able to easily identify, code and draw statistical data as needed.

Discharge disposition: In the case of a **death**, reminder to use the **PHISC discharge disposition 20 (Mortuary)** for a hospital event.

Reference: PHISC Updated Communication 3 for COVID-19 coding (07 April 2020)

COVID-19 Case Definition

National Institute for Communicable Diseases

Suspected COVID-19 case definition

Any person presenting with an acute (≤14 days) respiratory tract infection or other clinical illness compatible with COVID-19, or an asymptomatic person who is a close contact[a] of a confirmed[b] case

- Symptoms include ANY of the following respiratory symptoms: cough, sore throat, shortness of breath, anosmia (loss of sense of smell) or dysgeusia (alteration of the sense of taste), with or without other symptoms (which may include fever, weakness, myalgia, or diarrhoea)
- Note: Asymptomatic close contacts should not be routinely tested despite meeting the suspected case definition. However, testing may be indicated in certain circumstances (e.g. institutions such as care homes)

[a]**Close contact:** A person having had face-to-face contact (≤1 metre) or been in a closed space with a confirmed case for at least 15 minutes. This includes, amongst others, all persons living in the same household as a case, and people working closely in the same environment as a case. Healthcare workers or other people providing direct care for a case, while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, N95 respirator, eye protection). A contact in an aircraft sitting within two seats (in any direction) of the case, travel companions or persons providing care, and crew members serving in the section of the aircraft where the case was seated.

[b]**Confirmed case:** A person with laboratory confirmation of SARS-CoV-2 infection (using an RT-PCR assay), irrespective of clinical signs and symptoms. Symptomatic cases are considered infectious from 2-3 days before symptom onset to 14 days after symptom onset.

https://www.nicd.ac.za/wp-content/uploads/2020/07/NICD_DoH-COVID-19-Guidelines_Final_3-Jul-2020.pdf (accessed 29/12/2020)

COVID-19 Case Definition – Updated: 20 October 2020

Additional notes

Suspected COVID-19 case definition

Any person presenting with an acute (≤10 days) respiratory tract infection or other clinical illness compatible with COVID-19, or an asymptomatic person who is a close contact[1] of a confirmed[2] case

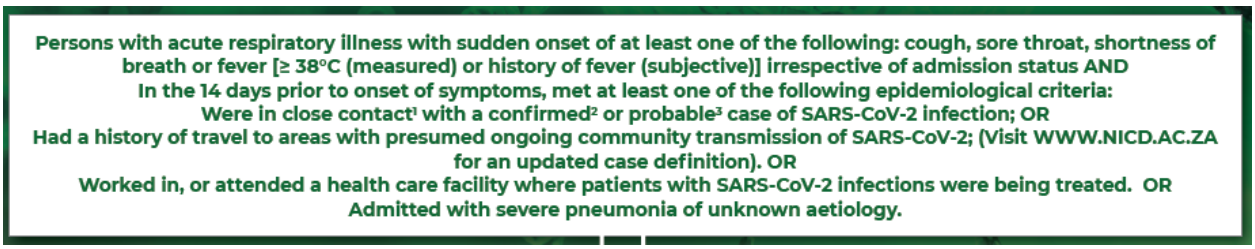
- Symptoms include ANY of the following respiratory symptoms: cough, sore throat, shortness of breath, anosmia (loss of sense of smell) or dysgeusia (alteration of the sense of taste), with or without other symptoms (which may include fever, weakness, myalgia, or diarrhoea)

1 Close contact: A person having had face-to-face contact (≤1 metre) or been in a closed space with a confirmed case for at least 15 minutes. This includes, amongst others, all persons living in the same household as a case, and people working closely in the same environment as a case. Healthcare workers or other people providing direct care for a case, while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, N95 respirator, eye protection). A contact in an aircraft sitting within two seats (in any direction) of the case, travel companions or persons providing care, and crew members serving in the section of the aircraft where the case was seated.

2 Confirmed case: A person with laboratory confirmation of SARS-CoV-2 infection (using an RT-PCR assay), irrespective of clinical signs and symptoms. Symptomatic cases are considered infectious from 2 days before symptom onset up to 10 days after symptom onset.

https://www.nicd.ac.za/wp-content/uploads/2020/11/Revised_COVID-19_NMC-Case-Def_29October20.pdf (accessed 18/11/2020)

Poster



https://www.nicd.ac.za/wp-content/uploads/2020/03/A0-nCoV-Poster-V1-PU-Feb-2020-G.pdf (accessed 18/11/2020)

Updated COVID-19 Coding Scenarios

Refer to PHISC COVID-19 communication 3 and 4 when assigning codes.

**** Please reference GSN0001 from the South African ICD-10 Morbidity Coding Standards and Guidelines document when selecting the primary diagnosis.***

***** Not all the ICD-10 codes assigned for the different scenarios will apply to the different practice types. The coding may differ depending on the treating healthcare provider's specialty or the facility. Please assign codes accordingly and consider the value that additional codes have on your data set.***

****** Use intervention/procedure codes to capture any mechanical ventilation or extracorporeal membrane oxygenation and identify any admission to intensive care unit.***

Reference:

WHO COVID-19 Case Definition
https://www.who.int/publications/i/item/WHO-2019-nCoV-Surveillance_Case_Definition-2020.2
(accessed 30/12/2020)

NICD COVID-19 Case Definition
https://www.nicd.ac.za/wp-content/uploads/2020/11/Revised_COVID-19_NMC-Case-Def_29October20.pdf
(accessed 03/02/2021)

Multisystem Inflammatory Syndrome in children (MIS-C)
https://www.nicd.ac.za/wp-content/uploads/2020/09/MIS_C-Case-Def_09-Sept-2020.pdf
(accessed 29/12/2020)

Disclaimer: ICD-10 coding guidelines for COVID-19 may change as related information and guidance from the World Health Organisation (WHO), National Institute of Communicable Diseases (NICD), and Department of Health (NDoH) is updated.

Scenario 1
Patient presented to the doctor's rooms with symptoms of COVID-19. Symptoms noted as a sore throat, headache, fever (temperature 39°C), dyspnoea and body pains. No history of travel or contact with confirmed or probable cases. Screened and referred for testing. Flagged as a suspected COVID-19 case.

* PDX: U07.2 COVID-19, virus not identified
SDX: J02.9 Acute pharyngitis, unspecified
SDX: R51 Headache
SDX: R50.9 Fever, unspecified
SDX: R06.0 Dyspnoea
SDX: R52.9 Pain, unspecified

* U07.2 / J02.9 / R51 / R50.9 / R06.0 / R52.9 (for line level coding)

Lab receives a request for a SARS-CoV-2 virus test.
Referral code U07.2 COVID-19, virus not identified

Note: The referral code, if available, should be placed in the designated space for a referral diagnosis within a claim.

Line level Z11.5 Special screening examination for other viral diseases

Note: Assign Z11.5 (Special screening examination for other viral diseases) for the SARS-CoV-2 virus test and Z01.7 (Laboratory examination) for any additional pathology screening/testing.

Scenario 2
Patient admitted into hospital with symptoms of COVID-19. Symptoms noted as a sore throat, headache, fever (temperature 39°C), dyspnoea and body pains. Flagged as a possible COVID-19 case. No history of travel or contact with confirmed or probable cases. Screened and referred for testing **prior to admission into hospital**. Patient placed in isolation.

* PDX: U07.2 COVID-19, virus not identified
SDX: J02.9 Acute pharyngitis, unspecified
SDX: R51 Headache
SDX: R50.9 Fever, unspecified
SDX: R06.0 Dyspnoea
SDX: R52.9 Pain, unspecified
SDX: Z29.0 Isolation

Scenario 3
Update to scenario 2. Patient developed viral pneumonia and results are positive for COVID-19.

* PDX: U07.1 COVID-19, virus identified
SDX: J12.8 Other viral pneumonia
SDX: Z29.0 Isolation

Note: Refer to DSN18 and PCS18 (Guidelines when using sign and symptom codes) Signs and/or symptoms inherent to a diagnosis.

Scenario 4
Patient admitted with pneumonia. Presents with a headache, fever (temperature 38,5°C) and dyspnoea. History of travel to Europe. Screened and tested for COVID-19 on admission to hospital. Placed in isolation.

* PDX: J18.9 Pneumonia, unspecified
  SDX: U07.2 COVID-19, virus not identified
  SDX: Z29.0 Isolation
  SDX: Z20.8 Contact with and exposure to other communicable diseases

Scenario 5
Update to scenario 4. Results are negative and COVID-19 ruled out. Patient treated for pneumonia.

* SDX: J18.9 Pneumonia, unspecified
  SDX: Z29.0 Isolation
  SDX: Z03.8 Observation for other suspected diseases and conditions
  SDX: Z20.8 Contact with and exposure to other communicable diseases

Scenario 6
Patient had an elective caesarean section for cephalo-pelvic disproportion. Outcome of delivery noted as a live born infant. Patient was screened and tested positive for COVID-19. No symptoms mentioned. No history of travel or contact with confirmed or probable cases. Newborn screened and tested. Awaiting results. Mother and newborn isolated and observed.

Mother:
* PDX: O33.9 Maternal care for disproportion, unspecified
  SDX: O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium
  SDX: U07.1 COVID-19, virus identified
  SDX: O82.0 Delivery by elective caesarean section
  SDX: Z37.0 Single live birth
  SDX: Z29.0 Isolation

Newborn:
* PDX: U07.2 COVID-19, virus not identified
  SDX: Z38.0 Singleton, born in hospital
  SDX: Z29.0 Isolation
  SDX: Z20.8 Contact with and exposure to other communicable diseases

Note: Information will only be coded if there is an account for the newborn.

Scenario 7
Update to scenario 6. Newborn results are negative. Mother re-tested and results are negative.

Mother:
* PDX: O33.9 Maternal care for disproportion, unspecified
  SDX: O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium
  SDX: U07.1 COVID-19, virus identified
  SDX: O82.0 Delivery by elective caesarean section
  SDX: Z37.0 Single live birth
  SDX: Z29.0 Isolation

Note: the coding remains the same for the mother as in scenario 6. Even though the retesting result in scenario 7 is negative, the patient was still positive at some point during the admission therefore the U07.1 must remain as part of the clinical record.

As the baby tested negative, code as follows:

Newborn:
* PDX: Z03.8 Observation for other suspected diseases and conditions
SDX: Z38.0 Singleton, born in hospital
SDX: Z29.0 Isolation
SDX: Z20.8 Contact with and exposure to other communicable diseases

If the baby tests positive, code as follows:

Newborn:
* PDX: U07.1 COVID-19, virus identified
SDX: P00.2 Fetus and newborn affected by maternal infectious and parasitic diseases
SDX: Z38.0 Singleton, born in hospital
SDX: Z29.0 Isolation
SDX: Z20.8 Contact with and exposure to other communicable diseases

Note: Information will only be coded if there is an account for the newborn.

Scenario 8
Patient 32 weeks pregnant, admitted with COVID-19. Symptoms on admission include diarrhoea, temperature 39°C, patient complaining of a headache, weak and dehydrated. Symptoms noted to be related to COVID-19. Patient works at a store where one of the employees tested positive for COVID-19. She was screened and tested as she worked closely with the employee. Her results were positive for COVID-19 and she was self-isolating prior to the admission. Patient placed in isolation.

* PDX: O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium
SDX: U07.1 COVID-19, virus identified
SDX: A09.0 Other and unspecified gastroenteritis and colitis of infectious origin
SDX: E86 Volume depletion
SDX: X58.52 Exposure to other specified factors, trade and service area, while working for income
SDX: Z29.0 Isolation
SDX: Z35.8 Supervision of other high-risk pregnancies
SDX: Z20.8 Contact with and exposure to other communicable diseases

Note: Signs and/or symptoms inherent to a diagnosis (usually, routinely or typically associated with a condition) should not be assigned in addition to the code assigned for the specified diagnosis unless these represent important problems in medical care in their own right and provide additional valuable clinical information for management of the patient.

Reference: DSN18 (The South African ICD-10 Morbidity Coding Standards and Guidelines document, version 6 and PCS18 (PHISC Addendum to the South African ICD-10 Morbidity Coding Standards and Guidelines document, version 4.

Scenario 9
Nursing sister tested positive for COVID-19 as a result of exposure in the workplace. All staff were screened and tested due an outbreak at the hospital. No signs or symptoms listed. She will be self-isolating and retested.

* PDX: U07.1 COVID-19, virus identified
SDX: X58.22 Exposure to other specified factors, school, other institution and public administrative area, while working for income
SDX: Z20.8 Contact with and exposure to other communicable diseases

Scenario 10
Patient was admitted to hospital on 11 June for a planned complicated removal of a total right hip prosthesis. He developed an infection due to an internal hip prosthesis which was inserted 4 months ago. He also has subacute osteomyelitis of the right hip and is a known Type 1 diabetic. He had a COVID-19 test done on 9 June which was negative. On 20 June he started complaining of loss of taste and smell and he was retested for COVID-19 on 21 June. His results were positive for COVID-19. The patient only had contact with hospital staff and doctors. According to the record, one of the nursing staff who attended to his wound in the ward, tested positive for COVID-19. This was established to be a hospital acquired COVID-19 infection.

* PDX: U07.1 COVID-19, virus identified
SDX: Y95 Nosocomial condition
SDX: T84.5 Infection and inflammatory reaction due to internal joint prosthesis
SDX: Y79.2 Orthopaedic devices associated with adverse incidents, prosthetic and other implants, materials and accessory devices
SDX: M86.25 Subacute osteomyelitis, pelvic region and thigh
SDX: E10.9 Type 1 diabetes mellitus without complications
SDX: Z20.8 Contact with and exposure to other communicable diseases
SDX: Z29.0 Isolation

Scenario 11
Patient admitted via ambulance with a history of pyrexia, central cyanosis and 3 days of progressive dyspnea. He is a known asthmatic and he is allergic to anesthetic agents. He lives with his son, who tested positive a week ago. A COVID-19 test was done after admission and detected the SARS-COV-2 virus. Patient was diagnosed with acute respiratory failure, Type 1 and lobar pneumonia due to COVID-19. Patient was nursed in isolation. Patient developed acute renal failure on day 3. He was moved to ICU and started on a ventilator. He deteriorated quickly and sadly passed away 2 days later.

* PDX: U07.1 COVID-19, virus identified
SDX: J96.00 Acute respiratory failure, Type I [hypoxic]
SDX: J18.1 Lobar pneumonia, unspecified
SDX: N17.9 Acute renal failure, unspecified
SDX: J45.9 Asthma, unspecified
SDX: Z99.1 Dependence on respirator
SDX: R99 Other ill-defined and unspecified causes of mortality
SDX: Z29.0 Isolation
SDX: Z20.8 Contact with and exposure to other communicable diseases
SDX: Z88.4 Personal history of allergy to anaesthetic agent

Note: Refer to DSN**1801* ***Coding a Death.
The use of R99 other ill-defined and unspecified causes of mortality is not mandatory.

Scenario 12
The patient, the driver was in a motor vehicle accident with another vehicle and sustained an open fracture of the femoral shaft, a closed fracture of the lower end of the radius and a fracture of the pelvis. The patient had emergency surgery for the fractured femur and suture of kidney injury.
Screened and tested for COVID-19 on admission.

* PDX: S72.31 Fracture of shaft of femur, open
SDX: S37.00 Injury of kidney, without open wound into cavity
SDX: S32.80 Fracture of other and unspecified parts of lumbar spine and pelvis, closed
SDX: S52.50 Fracture of lower end of radius, closed
SDX: V43.59 Car occupant injured in collision with car, pick-up truck or van, driver, traffic accident, during unspecified activity
SDX: Z11.5 Special screening examination for other viral diseases

Scenario 13
A patient who was 10 weeks pregnant at the time, was tested for COVID-19 because her husband tested positive 8 days ago and she developed severe headaches and a dry cough. The SARS-CoV-2 test was positive. She was admitted to hospital on 23 June now 11 weeks pregnant, with severe abdominal cramps and PV bleeding. She had a spontaneous abortion later that day.

* PDX: O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium
SDX: U07.1 COVID-19, virus identified
SDX: O03.9 Spontaneous abortion, complete or unspecified, without complication
SDX: Z20.8 Contact with and exposure to other communicable diseases

Scenario 14
Patient had an elective caesarean section for cephalo-pelvic disproportion. Outcome of delivery noted as a live born infant. Patient was screened and tested for COVID-19 during admission. Results were negative. No symptoms mentioned. No history of travel or contact with confirmed or probable cases.

* PDX: O33.9 Maternal care for disproportion, unspecified
SDX: O82.0 Delivery by elective caesarean section
SDX: Z37.0 Single live birth
SDX: Z11.5 Special screening examination for other viral diseases

Scenario 15
38 year old patient admitted with “Post COVID-19 syndrome”. She was diagnosed with COVID-19 two months ago. Her symptoms are noted as dyspnea, fatigue, abdominal pain and pain in hands and feet. Experiences episodes of pyrexia. Her temperature, on admission was normal. Patient claims that she was healthy and able to run 5km without any effort. Becomes breathless and is easily fatigued on minimal exertion. No pre-existing medical conditions.

* PDX: R06.0 Dyspnoea
SDX: R53 Malaise and fatigue
SDX: R10.4 Other and unspecified abdominal pain
SDX: M79.64 Pain in limb, hand
SDX: M79.67 Pain in limb, ankle and foot
SDX: U09.9 Post COVID-19 condition, unspecified

- *Assign codes for post COVID-19 syndrome as per **GSN**0013 **Coding of syndromes**.*
- *Assign an additional post COVID-19 condition code or a history code based on the information available and with reference to **DSN**2134 **The use of History Codes***

📖 Refer to information below “when is a person deemed to no longer have COVID-19”.

U09.9 Post COVID-19 condition, unspecified

Note: This optional code serves to allow the establishment of a link with COVID-19. This code is not to be used in cases that still are presenting COVID-19.

U08.9 Personal history of COVID-19, unspecified

Note: This optional code is used to record an earlier episode of COVID-19, confirmed or probable that influences the person's health status, and the person no longer suffers of COVID-19. This code should not be used for primary mortality tabulation.

Scenario 16
Nursing sister referred for counselling. Experiencing burn-out. Complains of physical and mental strain due to current working conditions (long hours and challenging working conditions). Feeling socially isolated as a result of the COVID-19 pandemic.

* PDX: Z73.0 Burn-out
SDX: Z56.6 Other physical and mental strain related to work
SDX: Z60.8 Other problems related to social environment
SDX: Z71.8 Other specified counselling
SDX: Z65.5 Exposure to disaster, war and other hostilities

* Z73.0 / Z56.6 / Z60.8 / Z71.8 / Z65.5 (for line level coding)

Note: A more specific code such as F43.1 (Post-traumatic stress disorder) can be assigned as determined by the Mental Health Professional.

Z65.5 is assigned as the nursing sister has been exposed to a disaster. A National State of Disaster was declared on 15 March 2020 due to the COVID-19 outbreak which was declared a global pandemic. (Reference: Section 3 of the Disaster Management Act, 2002) (Act No. 57 of 2002)

Scenario 17
70 year old patient tested positive for COVID-19. Referred for counselling. Extremely anxious and concerned about his health, family and wellbeing. He has to self-isolated which means that he needs to move out of his home. He is self-employed and concerned about losing his contract and financial income.

* PDX: R45.8 Other symptoms and signs involving emotional state
  SDX: Z56.2 Threat of job loss
  SDX: Z59.8 Other problems related to housing and economic circumstances
  SDX: U07.1 COVID-19, virus identified
  SDX: Z71.8 Other specified counselling

* R45.8 / Z56.2 / Z59.8 / U07.1 / Z71.8 (for line level coding)

> ***Note: A more specific code such as F41.9 (Anxiety disorder, unspecified) or F43.1 (Post-traumatic stress disorder) can be assigned if diagnosed by the Mental Health Professional.***

Scenario 18
Patient diagnosed with post-traumatic stress disorder as a result of the COVID-19 pandemic.

* PDX: F43.1 Post-traumatic stress disorder
  SDX: Z65.5 Exposure to disaster, war and other hostilities

* F43.1 / Z65.5 (for line level coding)

> ***Note:*** *Z65.5 is assigned as the patient has been exposed to a disaster. A National State of Disaster was declared on 15 March 2020 due to the COVID-19 outbreak which was declared a global pandemic. (Reference: Section 3 of the Disaster Management Act, 2002) (Act No. 57 of 2002)*

Scenario 19
80 year old patient for counselling, extremely anxious and fears being infected with COVID-19.

* PDX: Z71.1 Person with feared complaint in whom no diagnosis is made
  SDX: Z65.5 Exposure to disaster, war and other hostilities
  SDX: Z71.8 Other specified counselling

* Z71.1 / Z65.5 / Z71.8 (for line level coding)

> ***Note:*** *Z65.5 is assigned as the patient has been exposed to a disaster. A National State of Disaster was declared on 15 March 2020 due to the COVID-19 outbreak which was declared a global pandemic. (Reference: Section 3 of the Disaster Management Act, 2002) (Act No. 57 of 2002)*

Scenario 20
50 year female patient admitted for a hysterectomy for uterine fibroids. As per history, patient has asthma and on eltroxin for hypothyroidism. Had COVID-19 10 months ago. No associated problems mentioned.

PDX: D25.9 Leiomyoma of uterus, unspecified
SDX: M8890/0 Leiomyoma, NOS, benign
SDX: J45.9 Asthma, unspecified
SDX: E03.9 Hypothyroidism, unspecified
SDX: U08.9 Personal history of COVID-19, unspecified

U08.9 Personal history of COVID-19, unspecified

Note: This optional code is used to record an earlier episode of COVID-19, confirmed or probable that influences the person's health status, and the person no longer suffers of COVID-19. This code should not be used for primary mortality tabulation.

Paediatric Multisystem Inflammatory Syndrome – Temporally Associated with SARS-CoV-2 (PIM-TS) syndrome, paediatric multisystem inflammatory syndrome (PMIS / PIMS) or multisystem inflammatory syndrome in children (MIS-C) post COVID-19

📖 **COVID-19 (Suspected, Probable or Confirmed) Case definition as this may affect code selection**

Scenario 1
Confirmed MIS-C. Meets case definition. Contact with known positive case **and/or** positive SARS-CoV-2 antibody test **and/or** positive SARS-2-Cov RT PCR.

1. If positive SARS-CoV-2 RT-PCR (reverse transcription real-time PCR)
* PDX: U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified
SDX: U07.1 COVID-19, virus identified

2. If positive antibody test
and the patient is known to have had COVID-19

* PDX: U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified
SDX: U09.9 Post COVID-19 condition, unspecified

3. If positive antigen test;
* PDX: U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified
SDX: U07.1 COVID-19, virus identified

4. If considered a likely contact with an individual with COVID-19
* PDX: U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified
SDX: U07.2 COVID-19, virus not identified

Scenario 2
Presumed MIS-C: has clinical and lab features suggestive of MIS-C, suspected to be timeously associated with SARS-CoV-2 due to contemporaneous community transmission, **AND** no proven epidemiological contact **AND** COVID serology not available/not done **AND** negative SARS-Cov-2 PCR.

PDX: Assign codes for signs and/or symptoms

Or

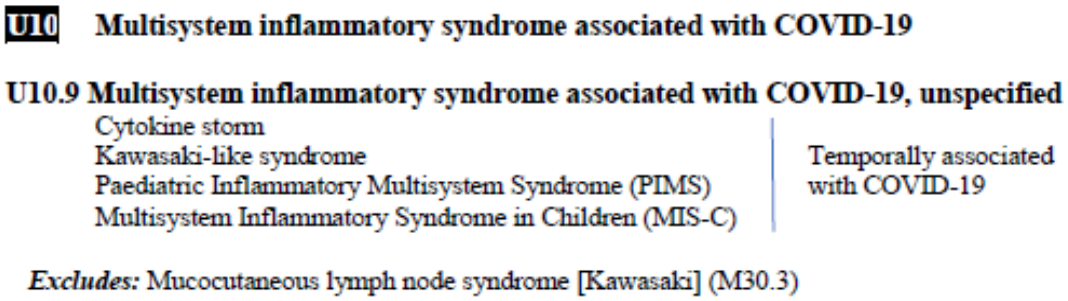
PDX: Assign codes for signs and/or symptoms
SDX: U07.2 COVID-19, virus not identified
SDX: Z20.8 Contact with and exposure to other communicable diseases

Scenario 3
Kawasaki disease felt to be associated with SARS-CoV-2. Classic or incomplete/atypical Kawasaki disease **AND** contact with known COVID-19 positive case **and/or** positive SARS-CoV-2 antibody test **and/or** positive SARS-2-Cov RT PCR.

1. If contact with known COVID-19 positive case
If Kawasaki-like syndrome:
* PDX: U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified
  SDX: U07.2 COVID-19, virus not identified

2. If positive antibody test and patient known to have had COVID-19
If Kawasaki-like syndrome
* PDX: U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified
  SDX: U09.9 Post COVID-19 condition, unspecified

3. If positive SARS-CoV-2 RT-PCR
If Kawasaki-like syndrome
* PDX: U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified
  SDX: U07.1 COVID-19, virus identified



U10 Multisystem inflammatory syndrome associated with COVID-19

U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified

Cytokine storm
Kawasaki-like syndrome
Paediatric Inflammatory Multisystem Syndrome (PIMS)
Multisystem Inflammatory Syndrome in Children (MIS-C)

Temporally associated with COVID-19

Excludes: Mucocutaneous lymph node syndrome [Kawasaki] (M30.3)

Scenario 4
Kawasaki disease not felt to be associated with SARS-CoV-2
Classic or incomplete Kawasaki disease **AND** No atypical features **AND** no definite COVID contact **AND** COVID serology not available **AND** negative SARS-2-Cov RT PCR.

PDX: M30.3 (Mucocutaneouslymph node syndrome [Kawasaki])

Additional examples:

Example 1: Confirmed MIS-C case
11-year-old girl presents with 3-day history of fever, severe abdominal pain, some nausea and diarrhoea. On examination she had mild conjunctival infection, tender abdomen with no clear evidence of appendicitis/acute abdomen. Cardiovascular examination reveals a gallop, but no impaired perfusion or shock. Blood tests reveal markedly raised inflammatory markers, lymphopenia, mild hyponatremia and elevated ferritin. Echo normal. Her mother had a mild sore throat 3 weeks previously, but was not tested for COVID-19. Antibody test is positive.

* PDX: U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified
SDX: U07.1 COVID-19, virus identified

Example 2: Confirmed MIS-C case
10-year-old admitted to ICU with fever, shock, non-specific rash and GIT symptoms. Had confirmed COVID-19 4 weeks previously. Clinical and laboratory features consistent with MIS-C.

* PDX: U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified
SDX: U07.1 COVID-19, virus identified

 Refer to information below “when is a person deemed to no longer have COVID-19”.

Example 3: Presumed MIS-C case
11-year-old girl presents with 3-day history of fever, severe abdominal pain, some nausea and diarrhoea. On examination she had mild conjunctival infection, tender abdomen with no clear evidence of appendicitis/acute abdomen. Cardiovascular examination reveals a gallop, but no impaired perfusion or shock. Blood tests reveal markedly raised inflammatory markers, lymphopenia, mild hyponatremia and elevated ferritin. Echo normal. Her mother had a mild sore throat 3 weeks previously but was not tested for COVID-19. Antibody testing is not available. SARS-CoV-2 RT PCR is negative.

PDX: Assign codes for signs and/or symptoms

Or

PDX: Assign codes for signs and/or symptoms
SDX: Z20.8 Contact with and exposure to other communicable diseases
*if mother considered to be a suspect for COVID-19

Example 4: Presumed MIS-C case
10-year-old admitted to ICU with fever, shock, non-specific rash and GIT symptoms. No history of recent respiratory illness personally or in household. Clinical and laboratory features consistent with MIS-C. SARS-CoV-2 PCR negative and antibody testing not done. Timing of illness occurs few weeks after known community transmission of SARS-CoV-2 in area.

PDX: Assign codes for signs and/or symptoms
SDX: U07.2 COVID-19, virus not identified
SDX: Z20.8 Contact with and exposure to other communicable diseases

Example 5: Classic Kawasaki disease not associated with SARS-CoV-2
4m old with classic features of Kawasaki disease. SARS-CoV-2 PCR negative, antibody test not done. No known COVID contact, but disease occurring 4 weeks after time period when community transmission was taking place.

PDX: M30.3 Mucocutaneous lymph node syndrome [Kawasaki]

Example 6: Classic Kawasaki disease associated with SARS-CoV-2
A 4-year-old meets all the criteria for Kawasaki disease. The SARS-CoV-2 PCR is positive.

* PDX: U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified
SDX: U07.1 COVID-19, virus identified

Dagger and Asterisk link for Pneumonia due to COVID-19

The dagger and asterisk combination can be assigned if the patient presents with both conditions at the same time and the viral pneumonia is deemed to be due to the COVID-19 by the medical practitioner.
U07.1+ COVID-19, virus identified
J17.1* Pneumonia in viral diseases classified elsewhere

When should COVID-19 be coded as a nosocomial infection?

Refer to the PHISC addition “hospital acquired conditions and infections” in the PHISC Addendum to the SA ICD-10 Morbidity Coding Standards and Guidelines document. COVID-19 should be documented as a nosocomial or hospital acquired infection before coded as such.

When is a person deemed to no longer have COVID-19?

If a repeat PCR test is done and the results are negative, or once the patient stops displaying symptoms and/or the clinician/medical doctor determines that the infection is no longer active.

- If the clinician/medical doctor documents that this is a post COVID-19 condition, it must be coded as such.
- When a patient, presents with symptoms consistent with post COVID-19 within a three-month period of being COVID-19 positive [or diagnosed with Long-COVID] – to be coded to U09.9 Post COVID syndrome.
- When a patient develops new symptoms consistent with COVID-19 illness within a three-month period of being COVID-19 positive – retesting is needed to confirm COVID-19. Assign U07.1 (COVID-19, virus identified) if PCR positive. In such cases it should not be coded as Long-COVID or Post COVID Syndrome.

What is the current guidance if a person retests positive by PCR?[5]

Retesting is unnecessary for persons who remain asymptomatic following recovery from COVID-19 during the first three months after the date of symptom onset. When a positive test occurs less than three months after the person's symptoms, a positive test could be a new infection or a persistently positive test associated with the previous disease.

Retesting is recommended in persons who develop new symptoms consistent with COVID-19 illness during the first three months since the date of early symptoms. Alternative causes of the symptoms should first be investigated before retesting. If reinfection is suspected, repeat isolation and contact tracing may be needed. Clinicians and public health authorities should consider reinfection if a positive test occurs more than three months after the onset of a person's symptoms. Until there is more information, knowing whether a person with a positive test in these situations will transmit to others must be made on a case-by-case basis. Potentially infectious persons should undergo evaluation, including retesting, and remain isolated until they again meet the criteria for discontinuation of isolation. Contact tracing during the person's second period of symptoms is required.

Reference: National Institute for Communicable Diseases (NICD)
https://www.nicd.ac.za/covid-19-re-infection-your-questions-answered/ (accessed 17/05/2021)

Which ICD-10 code should be assigned for a SARS CoV-2 Antibody Test?

As an interim measure, Z11.5 (Special screening examination for other viral diseases) can be assigned.

COVID-19 and the use of B34.2 and B97.2

B34.2 and B97.2 are not to be assigned together with U07.1 (COVID-19, virus identified) and U07.2 (COVID-19, virus not identified).

- B34.2 Coronavirus infection, unspecified site
- B97.2 Coronavirus as the cause of diseases classified to other chapters

Which ICD-10 code should be assigned for the COVID-19 vaccination?

U11.9 Need for immunization against COVID-19, unspecified

U11.9 Need for immunization against COVD-19, unspecified

Note: This code should not be used for international comparison or for primary mortality coding. This optional code is intended to be used when a person who may or may not be sick encounters health services for the specific purpose of receiving a COVID-19 vaccine.

Prophylactic COVID-19 vaccination

Excludes: immunization not carried out (Z28.-)

[5] National Institute for Communicable Diseases (NICD)

How should you code an adverse effect of a COVID-19 vaccine?

Example
Patient complaining of headaches, fatigue and muscle aches following COVID-19 vaccine

PDX: R51 Headache
SDX: R53 Malaise and fatigue
SDX: M79.19 Myalgia, site unspecified
SDX: U12.9 COVID-19 vaccines causing adverse effects in therapeutic use, unspecified

- **U12.9 is an external cause code and is not valid in the primary position.**

U12.9 COVID-19 vaccines causing adverse effects in therapeutic use, unspecified

Note: This code is to be used as an external cause code (i.e. as a subcategory under Y59 *Other and unspecified vaccines and biological substances*). In addition to this, a code from another chapter of the classification should be used indicating the nature of the adverse effect.

Correct administration of COVID-19 vaccine in prophylactic therapeutic use as the cause of any adverse effect.

Which ICD-10 code should be assigned for anaemia due to COVID-19?

Assign a code such as D64.8 (Other specified anaemias) or a specific code for the type of anaemia due to COVID-19.

Example
PDX: U07.1 COVID-19, virus identified
SDX: D64.8 Other specified anaemias

Or

PDX: D64.8 Other specified anaemias
SDX: U09.9 Post COVID-19 condition, unspecified

Which ICD-10 codes should be assigned when treating patients post hospitalisation for COVID-19?

Scenario 1
Patient discharged following admission for COVID-19. To continue physio post discharge as part of ongoing treatment.
Until when should U07.1 (COVID-19, virus identified) be assigned?

📖 Refer to information below “when is a person deemed to no longer have COVID-19”.

Scenario 2
Patient had COVID-19 two months ago. Having difficulty breathing and experiencing pains in hands and feet. Deemed to be associated with COVID-19.

PDX: R06.0 Dyspnoea
SDX: M79.64 Pain in limb, hand
SDX: M79.67 Pain in limb, ankle and foot
SDX: U09.9 Post COVID-19 condition, unspecified

 Refer to information below “when is a person deemed to no longer have COVID-19”.

Which code should be assigned for the history of a COVID-19 vaccination?

Z92.8 (Personal history of other medical treatment) to be used as there is not a specific code to indicate history of a COVID-19 vaccination.

Coding Multiple Infarct Syndrome due to COVID-19

"Multi-infarct" means that multiple areas of the brain have been injured due to a lack of blood from a series of small strokes. Blockages in the arteries of the brain usually cause a stroke (infarction), but sometimes there are no stroke symptoms.

Example 1:
Pt diagnosed with multiple infarct syndrome due to COVID-19. Infarcts are due to emboli in precerebral and cerebral arteries.

PDX: U07.1+ COVID-19, virus identified
SDX: I68.8* Other cerebrovascular disorders in diseases classified elsewhere
SDX: I63.1 Cerebral infarction due to embolism of precerebral arteries
SDX: I63.4 Cerebral infarction due to embolism of cerebral arteries

Example: 2
Patient diagnosed with COVID-19 had multiple cerebral infarctions due to thrombosis of cerebral arteries.

PDX: U07.1 COVID-19, virus identified
SDX: I63.3 Cerebral infarction due to thrombosis of cerebral arteries

Example 3:
Patient diagnosed with COVID-19 had thrombosis/embolism of cerebral artery not resulting in cerebral infarction.

PDX: U07.1 COVID-19, virus identified
SDX: I66.9 Occlusion and stenosis of unspecified cerebral artery

Example 4:
Patient had COVID-19 two months ago. Admitted with infarction due to embolism of both anterior and middle cerebral arteries. According to medical practitioner it is associated with COVID-19.

PDX: I63.3 Cerebral infarction due to thrombosis of cerebral arteries
SDX: U09.9 Post COVID-19 condition, unspecified

PCS11 Diseases of the digestive system (K00 – K93)

DSN11 Diseases of the digestive system (K00 – K93)

PHISC Guideline for the coding of liver failure caused by chronic viral Hepatitis C infection

Assign a code for the liver failure followed by the cause of the liver failure

Example:
Patient has liver failure caused by chronic viral Hepatitis C infection

PDX: K72.9 Hepatic failure, unspecified
SDX: B18.2 Chronic viral hepatitis C

Coding Appendagitis

Appendagitis
An older, nonspecific term for inflammation of any "appendage" (e.g., epiploic appendages); now known as epiploic appendices.
https://medical-dictionary.thefreedictionary.com/appendagitis (accessed 28/06/2023)

What is epiploic appendagitis?
Epiploic appendagitis is a rare condition that causes intense stomach pain and inflammation. It's often mistaken for other conditions, like diverticulitis or appendicitis. It's caused by a loss of blood flow to one of your epiploic appendages, which are small fat-filled sacs that line the outside of the colon and large intestine.
Unlike the conditions that it's often confused with, epiploic appendagitis usually doesn't require surgical treatment and can often resolve on its own.
https://www.healthline.com/health/epiploic-appendagitis (accessed 28/06/2023)

Example 1:
A 20-year-old man admitted via the emergency department with complaints of constant pain and tenderness in the left iliac fossa area. The patient does not have any fever and blood tests, including white cell count, shows no abnormalities. An abdominal x-ray revealed no evidence of bowel obstruction or free air. A CT abdomen confirmed torsion of the epiploic appendage and the treating clinician confirmed appendagitis.

PDX: K66.8 Other specified disorders of peritoneum

Coding Pneumoperitoneum

Assign K66.8 (Other specified disorders of peritoneum) in the absence of a specific code for this condition.

PCS12 Diseases the skin and subcutaneous tissue (L00 – L99)

Coding of decubitus ulcers and pressure areas

Multiple Pressure Ulcers
For multiple pressure ulcers, assign as many codes from category L89.- as needed to identify all the pressure ulcers.

Example:
Patient admitted from home with multiple pressure ulcers. Stage IV on sacrum, stage II on heels and shoulder blades and stage I on back of head.

PDX: L89.3 Stage IV decubitus ulcer
SDX: L89.1 Stage II decubitus ulcer
SDX: L89.0 Stage I decubitus ulcer and pressure area

Unspecified Stage Pressure Ulcers
When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage.

Example:
Patient admitted to the wound clinic for treatment of pressure ulcer on left heel.

PDX: L89.9 Decubitus ulcer and pressure area, unspecified

Patient admitted with pressure ulcer evolving into another stage during the admission
If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for the highest stage reported for that site.

Example:
Patient admitted with Streptococcus pneumoniae, ventilated from admission. Stage II pressure ulcer of buttocks recorded upon admission. The treating clinician requested a hands-off approach care for first 4 days. Re-assessment of the pressure ulcer on day 5 of admission confirmed that pressure ulcer progressed to Stage III pressure ulcer.

PDX: J13 Pneumonia due to Streptococcus pneumoniae
SDX: L89.2 Stage III decubitus ulcer
SDX: Z99.1 Dependence on respirator

Healing Pressure Ulcers
Pressure ulcer described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the patient record.
If the documentation does not provide information about the stage of the healing pressure ulcer, assign the appropriate code for unspecified stage.

Patient admitted with a bedsore, stage III, after theatre and treatment the wound healed well and the patient was discharged with what could be seen as a stage I bedsore.

PDX: L89.2 Stage III decubitus ulcer

Healed Pressure Ulcers
History coding of healed pressure ulcer is only assigned when clinically appropriate and relevant to admission.

- Z87.2 Personal history of diseases of the skin and subcutaneous tissue

If not relevant to the admission, no ICD-10 coding is assigned if the documentation states that the pressure ulcer is completely healed.

PCS13 Diseases of the musculoskeletal system and connective tissue (M00 – M99)

PCS1301 **Coding of anterior spinal and vertebral artery compression syndrome of the lumbar region**

Assign M47.09 (Anterior spinal and vertebral artery compression syndromes (G99.2*), site unspecified) for cases of **anterior spinal and vertebral artery compression syndrome** affecting the lumbar region until site-specific options can be accommodated in the SA ICD-10 MIT.

Example:
A 62-year-old female presented with anterior spinal artery compression syndrome of the lumbar region.

PDX: M47.09+ (Anterior spinal and vertebral artery compression syndromes (G99.2*), site unspecified)
SDX: G99.2* (Myelopathy in diseases classified elsewhere)

PCS14 Diseases of the genitourinary system (N00 – N99)

DSN14 Diseases of the genitourinary system (N00 – N99)

PCS1401 Coding of acute on chronic renal failure

Assign ICD-10 codes for both acute kidney failure and chronic kidney disease or end stage renal disease if clearly documented by the medical practitioner as there is no ICD-10 code that describes an acute exacerbation of chronic kidney disease or end stage renal disease.

Example 1:
Patient admitted with acute kidney failure and a urinary tract infection. Known to have chronic kidney disease.

PDX: N17.9 Acute renal failure, unspecified
SDX: N39.0 Urinary tract infection, site not specified
SDX: N18.9 Chronic kidney disease, unspecified

PCS15 Diseases of Pregnancy, Childbirth and the Puerperium (O00 – O99)

DSN1052 Pregnancy

HELLP syndrome (O14.2)

PHISC example added:
A patient [gestation 36/40] with eclampsia in pregnancy, developed HELLP Syndrome which resulted in a ruptured liver. The patient was taken to theatre for suturing of the liver and an emergency caesarean section was performed. She is in ICU and hemodynamically unstable and the baby is in neonatal ICU.

Mother's record:
PDX: O26.6 Liver disorders in pregnancy, childbirth and the puerperium
SDX: O14.2 HELLP syndrome
SDX: O15.0 Eclampsia in pregnancy
SDX: O60.3 Preterm delivery without spontaneous labour
SDX: O82.1 Delivery by emergency caesarean section
SDX: Z37.0 Single live birth

DSN1503 Labour and Delivery

PHISC Guideline: ICD-10 codes to be assigned on claims for the transporting of a patient in labour

For normal labour without complications such as haemorrhage, obstruction, preterm labour or premature rupture of membranes (PROM) etc. and where the baby is not delivered in the ambulance, assign a code from the following range of ICD-10 codes:

Z34.0 Supervision of normal first pregnancy
Z34.8 Supervision of other normal pregnancy
Z34.9 Supervision of normal pregnancy, unspecified

If the patient has a high risk pregnancy then assign a code from the following range of ICD-10 codes:

Z35.0 Supervision of pregnancy with history of infertility
Z35.1 Supervision of pregnancy with history of abortive outcome
Z35.2 Supervision of pregnancy with other poor reproductive or obstetric history
Z35.3 Supervision of pregnancy with history of insufficient antenatal care
Z35.4 Supervision of pregnancy with grand multiparity
Z35.5 Supervision of elderly primigravida
Z35.6 Supervision of very young primigravida
Z35.7 Supervision of high-risk pregnancy due to social problems
Z35.8 Supervision of other high-risk pregnancies
Z35.9 Supervision of high-risk pregnancy, unspecified

- If it is a preterm labour, or there are other complications (PROM, haemorrhage etc.) or the baby is delivered in the ambulance, then assign the appropriate ICD-10 code.

PHISC addition to indicate when O68.9 (Labour and delivery complicated by fetal stress, unspecified) should be assigned.

Labour and delivery complicated by fetal stress

Example:
Patient had an emergency caesarean section. Labour was complicated by foetal distress. Liveborn infant delivered.

PDX: O68.9 Labour and delivery complicated by fetal stress, unspecified
SDX: O82.1 Delivery by emergency caesarean section
SDX: Z37.0 Single live birth

PHISC amendment to the definition of preterm labour

Preterm Labour
Onset (spontaneous) of labour before 37 completed weeks of gestation.

O60.0 Preterm labour without delivery
Labour occurring before 37 completed weeks of pregnancy, without delivery

O60.1 Preterm spontaneous labour with preterm delivery
Labour occurring before 37 completed weeks of pregnancy with a delivery

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

O60.3 Preterm delivery without spontaneous labour

Example:
Patient was admitted into hospital at 30 weeks of gestation due to premature labour. A tocolytic was administered to suppress contractions. On day three, fetal distress was noted and an emergency caesarean section was performed and a live born infant was delivered.

PDX: O68.9 Labour and delivery complicated by fetal stress, unspecified
SDX: O60.1 Preterm spontaneous labour with preterm delivery
SDX: O82.1 Delivery by emergency caesarean section
SDX: Z37.0 Single live birth

PHISC amendment to: Coding of Neoplasms and Deliveries

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

PDX: O99.8 Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium
SDX: C52 Malignant neoplasm of vagina
SDX: M8000/3 Neoplasm, malignant, primary site
SDX: O82.0 Delivery by elective caesarean section
SDX: Z37.0 Single live birth

Guideline when coding obesity in pregnant patients
O99.2 Endocrine, nutritional and metabolic diseases complicating pregnancy, childbirth and the puerperium together with a code from E66.– should only be assigned if mentioned as such in the medical record. This should not be confused with O26.0 Excessive weight gain in pregnancy.

📖 **DSN**0402 **Obesity**

Coding of HIV / AIDS and Deliveries

📖 **DSN**1503 **Labour and Delivery – Coding of HIV / AIDS and Deliveries**
📖 **GSN**0001 **Primary Diagnosis**

Refer to **GSN**0001 **Primary Diagnosis** when selecting the primary diagnosis.

Assign a code for the reason for the caesarean section.
O98.7 (Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium) is not always the reason the caesarean section and will be assigned as the primary diagnosis if documented as HIV disease without further information.

* PHISC changes made to the examples below “Coding of HIV / AIDS and Deliveries” in the South African ICD-10 Morbidity Coding Standards and Guidelines document.

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

PDX: O82.0 Delivery by elective caesarean section
SDX: Z37.0 Single live birth
SDX: Z21 Asymptomatic human immunodeficiency virus [HIV] infection status
* *O98.7 removed from the code set.*

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

PDX: O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
SDX: B24 Unspecified Human Immunodeficiency Virus [HIV] disease
SDX: O82.0 Delivery by elective caesarean section
SDX: Z37.0 Single live birth
* *Coding sequence changed.*

* *Example 2 removed*.

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

PDX: O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
SDX: B24 Unspecified Human Immunodeficiency Virus [HIV] disease
SDX: O80.0 Spontaneous vertex delivery
SDX: Z37.0 Single live birth
* *Coding sequence changed.*

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

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

* PHISC change to example 5 in the PHISC Addendum to the South African ICD-10 Morbidity Coding Standards and Guidelines document.

Example 5:
A patient had an elective caesarean section for cephalo-pelvic disproportion. Outcome of delivery is a live born infant. She is HIV positive.

PDX: O33.9 Maternal care for disproportion, unspecified
SDX: O82.0 Delivery by elective caesarean section
SDX: Z37.0 Single live birth
SDX: Z21 Asymptomatic human immunodeficiency virus [HIV] infection status
* *O98.7 removed from the code set.*

Elective and emergency caesarean section coding guideline

DSN1503 **Labour and Delivery – Delivery (O80 – O84)**

Example 1:
Patient had an emergency caesarean section for obstructed labour due to cephalopelvic disproportion. Delivered a healthy liveborn infant. Patient is HIV positive and asymptomatic.

PDX: O65.4 Obstructed labour due to fetopelvic disproportion
SDX: O82.1 Delivery by emergency caesarean section
SDX: Z37.0 Single live birth
SDX: Z21 Asymptomatic human immunodeficiency virus [HIV] infection status

- If an elective caesarean section was performed for cephalopelvic disproportion before the onset of labour, then assign

PDX: O33.9 Maternal care for disproportion, unspecified
SDX: O82.0 Delivery by elective caesarean section
SDX: Z37.0 Single live birth
SDX: Z21 Asymptomatic human immunodeficiency virus [HIV] infection status

Example 2:
A patient went for an emergency caesarean section, because of obstructed labour due to pelvic inlet contraction, she is also a known to have HIV/AIDS. *The caesarean section decreases the risk of exposure to HIV for the baby.* A liveborn infant was delivered

PDX: O65.2 Obstructed labour due to pelvic inlet contraction
SDX: O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
SDX: B24 Unspecified Human Immunodeficiency virus [HIV] disease
SDX: O82.1 Delivery by emergency caesarean section
SDX: Z37.0 Single live birth

 **DSN**1503 **Labour and Delivery – Coding of HIV/AIDS and Deliveries with Complications**

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

PDX: O85: Puerperal sepsis
SDX: O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
SDX: B24: Unspecified human immunodeficiency virus [HIV] disease
SDX: O82.0: Delivery by elective caesarean section
SDX: Z37.0: Single live birth
* *No change.*

* *Example 2 removed*.

PCS1501 **Assigning O30 (Multiple gestation) in combination with O31 (Complications specific to multiple gestation)**

Codes O30.- and O31.- can be assigned in combination to indicate complications specific to multiple gestation although there is an exclusion note below O30 (Multiple gestation) indicating, “complications specific to multiple gestation (O31.-).

Example 1:
Spontaneous delivery of a single live born infant. Earlier in the pregnancy there was an abortion of one of the twins.

PDX: O30.0 Twin pregnancy
SDX: O31.1 Continue pregnancy after abortion of one fetus or more
SDX: O80.0 Spontaneous vertex delivery
SDX: Z37.0 Single live born infant

Example 2:
Patient is pregnant with triplets, now in labour. One of the foetuses died in utero. Mother delivered 2 live babies and one stillborn via emergency caesarian section.

PDX: O30.1 Triplet pregnancy
SDX: O31.2 Continuing pregnancy after intrauterine death of one fetus or more
SDX: O84.2 Multiple delivery, all by caesarean section
SDX: O82.1 Delivery by emergency caesarean section
SDX: Z37.6 Other multiple births, some liveborn

PCS1501 **Coding cardiac arrest in pregnancy**

There must be clear documentation that the cardiac arrest with successful resuscitation was due to anaesthesia during labour or delivery when assigning O74.2 (Cardiac complications of anaesthesia during labour and delivery) and I46.0 (Cardiac arrest with successful resuscitation).

Example 1:
Following administration of general anesthesia for emergency caesarean section due to fetal distress, the mother suffered cardiac arrest. She was successfully resuscitated in theatre, procedure completed with live birth of baby boy.

PDX: O74.2 Cardiac complications of anaesthesia during labour and delivery
SDX: I46.0 Cardiac arrest with successful resuscitation
SDX: O68.9 Labour and delivery complicated by fetal stress, unspecified **or** O36.3 (Maternal care for signs of fetal hypoxia)
SDX: O82.1 Delivery by emergency caesarean section
SDX: Z37.0 Single live birth

- If the caesarean section was performed **before the onset of labour**, assign O36.3 (Maternal care for signs of fetal hypoxia).

Example 2:
During the second stage of delivery, 25-year-old female suffered cardiac arrest. Despite resuscitation efforts the mother passed away. Ventouse assisted delivery completed, still born baby girl delivered.

PDX: O75.4 Other complications of obstetric surgery and procedures
SDX: I46.9 Cardiac arrest, unspecified
SDX O81.4 Vacuum extractor delivery
SDX Z37.1 Single stillbirth
SDX: O95 Obstetric death of unspecified cause

DSN1801 **Coding a Death**
The use of R99 (Other ill-defined and unspecified causes of mortality) is not mandatory.

O95 should not be assigned as the PDX. The main condition treated during the admission should be assigned in the primary position.

Note: For use of categories O95-O97 reference should be made to the mortality coding rules and guidelines in Volume 2[6].

Example 3:
The patient suffered a cardiac arrest in the post-natal ward a day after a normal vertex delivery of her live born infant. She was successfully resuscitated and had an extended length of stay to ensure monitoring for cardiac stability. There seems to be no permanent cardiac damage. She was discharged and will be followed up by both the gynecologist and the cardiologist.

PDX: O75.4 Other complications of obstetric surgery and procedures
SDX: I46.0 Cardiac arrest with successful resuscitation
SDX: O80.0 Spontaneous vertex delivery
SDX: Z37.0 Single live birth

[6] International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Volume I, Tabular List 2014 Edition

Coding of Pregnancy and Trauma

When trauma-related and maternity-related conditions occur simultaneously as part of the same event, the primary diagnosis must be assigned in accordance with the current definition of primary diagnosis outlined in **GSN**0001 **Primary Diagnosis**.

PCS16 Certain conditions originating in the perinatal period (P00 – P96)

DSN1602 **Conditions originating in the perinatal and neonatal period**

 **DSN**1602 **Conditions originating in the perinatal and neonatal period**

PHISC addition to above standard:
Coding guideline based on the Coding Note below KB24 (Congenital pneumonia) in ICD-11:
Conditions arising in the perinatal period, even though death or morbidity occurs later, should, as far as possible, be coded to chapter 19, which takes precedence over chapters containing codes for diseases by their anatomical site. **For children less than 28 days old, assume that a reported condition developed in the perinatal period, unless the duration is stated, and the onset was after the first completed week of life[7].**
(Accessed 15/07/2024)

Example 4:
Newborn admitted with patent ductus arteriosus. Known to have Down's Syndrome. Developed pneumonia due to streptococcus group B.

PDX: Q25.0 Patent ductus arteriosus
SDX: P23.6 Congenital pneumonia due to Streptococcus, group B
SDX: Q90.9 Down's syndrome, unspecified
SDX: Z38.0 Singleton, born in hospital

Example 5:
Newborn admitted with patent ductus arteriosus. Known to have Down's Syndrome. Developed hospital acquired Klebsiella pneumonia.

PDX: Q25.0 Patent ductus arteriosus
SDX: P23.6 Congenital pneumonia due to other bacterial agents
SDX: B96.1 Klebsiella pneumoniae [K. pneumoniae] as the cause of diseases classified to other chapters
SDX: Y95 Nosocomial condition
SDX: Q90.9 Down's syndrome, unspecified
SDX: Z38.0 Singleton, born in hospital

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

PHISC guideline to above standard:

Z03.8 Observation for other suspected diseases and conditions must be assigned for babies born to mothers that have an infectious disease and are kept in hospital for observation.

Example 1:
Newborn kept in hospital for observation for possible infection following delivery

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

[7] WHO, ICD-11 for Mortality and Morbidity Statistics

DSN1605 **Fetal death of unspecified cause (P95)**

📖 **DSN**1605 **Fetal death of unspecified cause (P95)**

Whenever possible, fetal deaths should be classified according to the cause of death. P95 should only be used if the cause of death is unknown.

PHISC addition to above standard:
P95 should not be assigned as the outcome of delivery on the mother's record. Refer to DSN1503 Labour and Delivery.

📖 **DSN**2139 **Prophylactic drug administration in newborns**

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

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

PDX: Z38.0 Singleton, born in hospital
SDX: Z29.2 Other prophylactic chemotherapy

PHISC guideline:
Assign codes as per example 1 if the administration of prophylactic antibiotics is:

- because the mother had a previous streptococcus infection or
- the mother is a known carrier of Streptococcus, group B.

Z83.1 Family history of other infectious and parasitic diseases must be assigned as an additional code if the mother is a known carrier of Streptococcus, group B.

The coding must be updated with the appropriate ICD-10 code/s once a definitive diagnosis has been confirmed.

PCS18 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00 – R99)

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

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

PHISC additions to guideline:

'Sign and symptom' codes that usually begin with the letter 'R' are used if no definite diagnosis has been established at the end of an episode of health care or if a patient is treated symptomatically at a primary health care level. The information that permits the greatest degree of specificity and knowledge about the condition that necessitated care or investigation should be recorded. This should be done by stating a symptom, abnormal finding or problem, rather than qualifying a diagnosis as "possible", "questionable" or "suspected", when it has been considered but not established. Sign and symptoms are also allocated to relevant chapters in the classification and therefore may not be always identified as an "R" code e.g. backache is coded as "M54.99" and is allocated to chapter XIII (Diseases of the Musculoskeletal System and Connective Tissue).

Sign and symptom codes can be used as the main condition in the following situations:

a) **cases for which no more specific diagnosis can be made even after all the facts bearing on the case have been investigated;**

   Example:
   Patient admitted with haematuria. Cystoscopy performed but no abnormality detected.
   PDX: R31 Unspecified haematuria

b) **signs or symptoms existing at the time of initial encounter that proved to be transient (passing or temporary) and whose causes could not be determined;**

   Example:
   Patient is brought into hospital with 'confusion'. No cause is identified on examination.
   PDX: R41.0 Disorientation, unspecified

c) **provisional diagnosis in a patient who failed to return for further investigation or care;**

   Example:
   Patient admitted for excision biopsy of lump in neck but refused surgery on arrival in theatre.
   PDX: R22.1 Localised swelling, mass and lump, neck
   SDX: Z53.2 Procedure not carried out because of patient's decision for other and unspecified reasons

d) **cases referred elsewhere for investigation or treatment before the diagnosis was made;**

   Example:
   Patient admitted with chest pain. A myocardial infarction is suspected, so patient is transferred to a hospital with a coronary care unit.
   PDX: R07.4 Chest pain, unspecified

e) cases in which a more precise diagnosis was not available for any other reason;

Example 1:
Patient admitted with signs and symptoms resembling a schizotypal disorder. The treating doctor is unwilling to make a diagnosis at the time, and only records symptoms of visual hallucinations, agitation and stupor in the medical record
PDX: R44.1 Visual hallucinations
SDX: R45.1 Restlessness and agitation
SDX: R40.1 Stupor

Example 2:
The medical record states possible epilepsy, but the treating doctor is uncertain as the symptoms are suggestive of more than one diagnosis. Symptoms of fit and blackout are recorded by the treating doctor.
PDX: R56.8 Other and unspecified convulsions
SDX: R55 Syncope and collapse

f) symptom codes can be used as the main code when used together with a sequelae code (late effect)

Example:
Patient currently has dysphagia. This is a late effect (sequelae) of a CVA the patient had a year ago.
PDX: R13 Dysphagia
SDX: I69.4 Sequelae of stroke, not specified as haemorrhage or infarction

Diagnosis recorded as "possible" or "suggestive of" or "probable" or prefixed with a "?" or "query"
This will not be coded as if the given diagnosis is confirmed.
This will remain the case regardless of the treatment that has been provided to the patient.
In such circumstances the coder will record the relevant symptoms.
The terms "possible" and "suggestive of" and the use of the "?" will be taken to mean that there remained a significant element of doubt as to the actual diagnosis and that the differential diagnoses were still being considered (or that the patient appeared to be recovering so further investigations were not being undertaken but that there was a significant level of uncertainty over the actual diagnosis).
Where a diagnosis has been made and recorded but this diagnosis is subsequently proven to be incorrect, the final (actual diagnosis) will be coded. This will be the case regardless of the treatment that has been provided to the patient.

Certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right.

Codes from chapter 18 are assigned as secondary codes only when:

- the presence of the sign or symptoms makes a difference in the severity of the patient's condition and/or the care given
- the symptom persisted despite successful treatment of the suspected underlying condition
- they represent important problems in medical care in their own right e.g.
    - the symptom required its own evaluation or treatment
    - added to the resource usage
    - increased the severity of care and/or level of acuity
    - increased the length of stay

a) The cause of the signs and/or symptoms are known, but they are important problems in medical care requiring treatment. The signs and/or symptoms must be recorded in a secondary position, in addition to the known cause.

Example:
Patient admitted for treatment of hypertension. Patient was treated with nasal packs to control nasal haemorrhage. The nose bleed was considered to be related to her hypertension.
PDX: I10 Hypertension
SDX: R04.0 Epistaxis

b) Signs and/or symptoms inherent to a diagnosis (usually, routinely or typically associated with a condition) should not be assigned in addition to the code assigned for the specified diagnosis unless these represent important problems in medical care in their own right and provide additional valuable clinical information for management of the patient.

Example 1:
Patient presenting with photophobia, fever and neck stiffness. Final Diagnosis was Meningitis. Code only the definitive diagnosis – Meningitis.
PDX: G03.9 Meningitis, unspecified

Example 2:
Patient admitted with sickle-cell crisis and acute chest syndrome.
PDX: D57.0 Sickle-cell anaemia with crisis
Acute chest syndrome is a symptom usually, routinelyand/or typically associated with sickle cell crisis and therefore not coded separately.

Example 3:
A patient was admitted with pneumonia. Presented with coughing and had a fever.
Cough and fever are universally accepted as symptoms being typically associated with Pneumonia and do not need to be coded as additional information.
PDX: J18.9, Pneumonia, unspecified organism

Example 4:
A known diabetic is admitted with hyperglycaemia for stabilization of poorly controlled diabetes. Assign an additional code for the hyperglycaemia as this provides supplementary information regarding the reason for admission and the care rendered.
PDX: E10.- to E14.- with a fourth character of .6 “with other specified complications”
SDX: R73.9 Hyperglycaemia, unspecified

Coding guideline for “cannot tolerate oral medicine”

There is no specific ICD-10 code for “cannot tolerate oral medicine”. Assign a sign and/or symptom code for each specific case where relevant.

PCS19 Injury, poisoning and certain other consequences of external causes (S00 – T98)

DSN1901 **Poisoning, Overdose and Adverse Effects**

Poisoning

A poisoning is identified as the:

- Wrong dosage given or taken
- Wrong medication given or taken
- Medication given or taken by the wrong person
- Intoxication (other than cumulative effect)
- Overdose
- Correct medicine taken with alcohol causing an unexpected adverse effect.
- Correct medicine taken with non prescription drug, causing an unexpected adverse effect.
- Wrong route of administration
- Therapeutic misadventure
- Toxic effect / Toxicity

PHISC addition
Therapeutic misadventure – refer to definition of misadventure (**DSN**1906 **Complications of Surgery and Medical care**)

Guideline

- Assign a code for each drug if multiple drugs documented.
- Assign a code for each active ingredient of a combination drug sequencing the one with the highest strength in the absence of detailed information.
- Code the manifestation in addition to the poisoning code and then the external cause code.
- A poisoning will be coded as undetermined if it is not stated as accidental or intentional although the note below “event of undetermined intent” indicates “but not poisoning” in the ICD-10 Tabular List.

PHISC amendment to point 4 of the “Poisoning Guideline”:

Event of undetermined intent (Y10 – Y34)
Note: This section covers events where available information is insufficient to enable a medical or legal authority to make a distinction between accident, self-harm and assault. It includes self-inflicted injuries, but not poisoning, when not specified whether accidental or with intent to harm (X40-X49). Follow legal rulings when available[8].

[8] ICD-10 Tabular List, 2010 Edition

Herbal enemas

📖 **DSN**1903 **Herbal Enemas**

PHISC addition
A reaction to a herbal enema can be assigned as a poisoning or an adverse reaction depending on the circumstances.

Refer to definitions at **DSN**1901 **Poisoning, Overdose and Adverse Effects** when coding reactions to herbal enemas.

If related to a poisoning, code as follows:
PDX: T50.9 Poisoning, other and unspecified drugs, medicaments and biological substances
SDX: Y14.– Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent

If related to an adverse reaction, code as follows:
PDX: Assign a code for the adverse effect
SDX: Y57.9 Adverse effects in therapeutic use, drug or medicament, unspecified

Coding complications from Antiretrovirals (ARVs)

📖 **DSN**1901 **Poisoning, Overdose and Adverse Effects**

Example:
Patient developed lipodystrophy as a side effect of antiretrovirals (ARVs)

PDX: E88.1 Lipodystrophy, not elsewhere classified
SDX: Y41.5 Adverse effects in therapeutic use, antiviral drugs

📖 **DSN**1905 **Coding Injuries**

Sequencing rules when coding injuries[9]
PHISC amendment to point 4 and addition of point 5.

1. Code the internal injury as the main condition for internal injuries recorded with superficial injuries and / or open wounds.

Example:
Patient sustained an injury to the lung. Stab wound to back wall of chest.

PDX: S27.31 Other injuries of lung, with open wound into thoracic cavity
SDX: S21.2 Open wound of back wall of thorax
SDX: X99.99 Assault by sharp object, unspecified place, during unspecified activity

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

2. Code the intracranial injury as the main condition for fractures of skull and facial bones with associated intracranial injury.

Example: Closed fracture of vault of skull with concussion without open intracranial wound

PDX: S06.00 Concussion, without open intracranial wound
SDX: S02.00 Fracture of vault of skull, closed

3. Code intracranial haemorrhage as the main condition for intracranial haemorrhage recorded with other injuries to the head.

Example: Patient admitted with a fracture of the skull with a subdural haemorrhage following a fall from the balcony of his apartment.

PDX: S06.50 Traumatic subdural haemorrhage, without open intracranial wound
SDX: S02.90 Fracture of skull and facial bones, part unspecified, closed
SDX: W13.09 Fall from, out of or through building or structure, home, during unspecified activity

4. Code the fracture as the main condition for fractures recorded with open wounds of the same location. Follow the fracture coding rules, if the fracture is not stated as open or closed, code to closed.

Example: Fracture shaft of humerus with an open wound of the same site.

PDX: S42.31 Fracture of shaft of humerus, open

5. Code the fracture as the main condition for fractures. For open wounds not caused by an open fracture, assign additional coding for open wounds on other same anatomical site / other areas.

Example:
A cyclist was admitted via the emergency unit with a closed femoral shaft fracture as well as several open wounds on the thigh, hip area, knee and lower leg, not part of the fracture. Patient was hit by a car.

PDX: S72.30 Fracture of shaft of femur, closed
SDX: S71.7 Multiple open wounds of hip and thigh
SDX: S81.7 Multiple open wounds of lower leg
SDX: V13.49 Pedal cyclist injured in collision with car, pick-up truck or van, driver, traffic accident, during unspecified activity

🕮 **DSN**1906 **Complications of Surgery and Medical Care**

PHISC amendment to the definition of "Misadventure" in the SA ICD-10 Coding Standards and Guidelines document.

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

Mishaps in hospital, even if the patient does not sustain an injury

Example 1:
A 75 year old male patient was admitted for a biopsy of a lung mass. He fell while trying to sit on a chair a day after the procedure. No injury was sustained as per the clinical notes.

PDX: R91 Abnormal findings on diagnostic imaging of lung
SDX: Z04.3 Examination and observation following other accident
SDX: W07.28 Fall involving chair, school, other institution and public administrative area, while engaged in other specified activities

Example 2:
A 2 year child admitted for observation following a fall at home. ? Head injury mentioned. Child stable. No bruises noted.

PDX: Z04.3 Examination and observation following other accident
SDX: W19.09 Unspecified fall, home, during unspecified activity

 **DSN**2001 **External Cause Codes** – an external cause code should be assigned with Z04.–

 **DSN**1906 **Complications of Surgery and Medical Care**

PHISC addition
Healthcare Facility associated or acquired conditions and infections

Healthcare Facility associated or acquired conditions
A nosocomial condition is acquired or occurs while a patient is in a healthcare facility such as a hospital, sub-acute unit, physical rehabilitation unit, frail care facility etc.; this could be an infection or any other disease or condition for which the patient was not initially admitted but which was contracted or occurred while under medical care.

Healthcare Facility associated or acquired infections
An infection acquired in a healthcare facility by a patient who was admitted for a reason other than that infection. An infection occurring in a patient in a hospital or other healthcare facility in whom the infection was not present or incubating at the time of admission. This includes infections acquired in the healthcare facility but appearing after discharge, and also occupational infections among staff of the facility.

Assign Y95 Nosocomial condition:
- as per the WHO document for both nosocomial infections and conditions[10].
- when the condition is documented as nosocomial by the medical practitioner.

Y95 (Nosocomial condition) must **not** be assigned in addition to Y65.8 (Other specified misadventures during surgical and medical care), as this constitutes over-coding. The definition of a misadventure already implies that the condition resulted from medical treatment.

[10] Prevention of hospital-acquired infections, A practical guide, 2nd edition

Example 1:
A patient is admitted to the hospital and diagnosed with severe sepsis due to healthcare associated pneumonia. The medical doctor documented that her healthcare associated pneumonia was due to her recent hospitalization.

PDX: A41.9 Sepsis, unspecified
SDX: J18.–
SDX: R65.–
SDX: Y95 Nosocomial condition

Example 2:
A nursing student was admitted into the medical ward with a severe respiratory infection. After investigation it was confirmed as a streptococcal pneumonia. She subsequently also contracted a MRSA pneumonia. It was confirmed that she nursed a patient with MRSA, but there was no confirmation that her MRSA infection was acquired while working in the medical ward.

PDX: J15.4 Pneumonia due to other streptococci
SDX: J15.2 Pneumonia due to Staphylococcus
SDX: B95.6 *Staphylococcus aureus* as the cause of diseases classified to other chapters
SDX: U82.1 Resistance to methicillin

Example 3:
Patient admitted with UTI caused by bacterium *Klebsiella pneumonia*. The patient developed septicaemia during the stay at hospital. Patient died and it was confirmed that the septicaemia was hospital acquired.

PDX: A41.9 Sepsis, unspecified
SDX: Y95 Nosocomial condition
SDX: N39.0 Urinary tract infection, site not specified
SDX: B96.1 *Klebsiella pneumoniae* [*K. pneumoniae*] as the cause of diseases classified to other chapters
SDX: R99 Other ill-defined and unspecified causes of mortality

- The use of R99 is not mandatory

📖 **DSN**1801 **Coding a Death**

Example 4:
An elderly patient with documented diagnosis of intracerebral haemorrhage and a hospital acquired deep vein thrombosis (DVT) of the left leg.

PDX: I61.9 Intracerebral haemorrhage, unspecified
SDX: I80.2 Phlebitis and thrombophlebitis of other deep vessels of lower extremities
SDX: Y95 Nosocomial condition

Y95 Nosocomial condition must always be sequenced following the condition/s acquired in hospital.

DSN1906 **Complications of Surgery and Medical Care**

PHISC addition

Postprocedural complications

Example 1:
Patient diagnosed with atherosclerotic heart disease re-admitted 2 weeks after successful coronary artery bypass surgery. Patient complaining of decreased urinary output, swelling of extremities, shortness of breath, general weakness and fatigue and nausea. Following investigation, the treating clinician confirms that the renal failure is a result of the procedure performed 2 weeks earlier. Treatment for the renal failure is commenced.

PDX: N99.0 Postprocedural renal failure
SDX: I25.1 Atherosclerotic heart disease
SDX: Z95.1 Presence of aortocoronary bypass graft

Example 2:
Following a vaginal hysterectomy for 36-year-old female diagnosed with excessive and frequent menstruation with irregular cycle, pathology examination confirms iron deficiency anaemia. The treating clinician confirms that is it not due to recent surgery, but due to chronic secondary blood loss.

PDX: N92.1 Excessive and frequent menstruation with irregular cycle
SDX: D50.0 Iron deficiency anaemia secondary to blood loss (chronic)

Coding of a wound/ulcer as a result of the long-term use of a CPAP mask or ventilation harness

Assign an appropriate code from L89.- with an external cause code.
L89.0 Stage I decubitus ulcer and pressure area
L89.1 Stage II decubitus ulcer
L89.2 Stage III decubitus ulcer
L89.3 Stage IV decubitus ulcer
L89.9 Decubitus ulcer and pressure area, unspecified

Example:
Patient admitted with viral pneumonia due to COVID-19. Placed on CPAP due to respiratory failure. Developed a skin ulcer on the nose due to the extended use of a CPAP mask.

PDX: U07.1+ (COVID-19, virus identified)
SDX: J17.1* (Pneumonia in viral diseases classified elsewhere)
SDX: J96.99 (Respiratory failure, unspecified, Type unspecified)
SDX: L89.9 (Decubitus ulcer and pressure area, unspecified)
SDX: Y72.1 (Otorhinolaryngological devices associated with adverse incidents, therapeutic (nonsurgical) and rehabilitative devices)

- Select an appropriate code from J96.- if more information is available.

Coding of subcutaneous haematomas

There is no specific code for subcutaneous haematomas.

Example 1:
Patient developed an adverse reaction to the warfarin. Bleeding with subcutaneous haematomas all over her body.

PDX: R58 Haemorrhage, not elsewhere classified
SDX: R23.3 Spontaneous ecchymoses
SDX: Y44.2 Adverse effects in therapeutic use, anticoagulants

Example 2:
Patient developed an adverse reaction to the warfarin she has been using for the last 5 years. Bleeding with subcutaneous haematomas all over her body.

PDX: R58 Haemorrhage, not elsewhere classified
SDX: R23.3 Spontaneous ecchymoses
SDX: Y44.2 Adverse effects in therapeutic use, anticoagulants
SDX: Z92.1 Personal history of long-term (current) use of anticoagulants

Coding of post procedural infection and sepsis

📖 Refer to notes below code T81.4
Use an additional code to identify other manifestations of infection, such as sepsis or abscess.

Example 1:
Patient developed an intestinal abscess following a laparotomy a week ago. Infectious agent E.coli.

PDX: T81.4 (Infection following a procedure, not elsewhere classified)
SDX: K63.0 (Abscess of intestine)
SDX: B96.2 (Escherichia coli [E. coli] as the cause of diseases classified to other chapters)
SDX: Y83.8 (Abnormal reaction/later complication, without mention of misadventure at the time of the procedure, other surgical procedures)

Example 2:
Patient developed sepsis due to E. coli following an exploratory laparotomy.

PDX: T81.4 (Infection following a procedure, not elsewhere classified)
SDX: A41.5 (Sepsis due to other Gram-negative organisms)
SDX: Y83.8 (Abnormal reaction/later complication, without mention of misadventure at the time of the procedure, other surgical procedures)

Example 3:
Patient treated for a stitch abscess following the removal of a lipoma on the shoulder.

PDX: T81.4 (Infection following a procedure, not elsewhere classified)
SDX: L02.4 (Cutaneous abscess, furuncle and carbuncle of limb)
SDX: Y83.8 (Abnormal reaction/later complication, without mention of misadventure at the time of the procedure, other surgical procedures)

PHISC addition to the coding of bilateral fractures

The following guideline differs from that published in the SA ICD-10 Morbidity Coding Standards and Guidelines, Version 6 (as at April 2014).

While the code range T00–T07, including T02.4 and T02.5, accommodates bilateral fractures, a more specific code providing better clinical detail should be assigned.

Duplicate coding for bilateral fractures is permitted only in exceptional circumstances where the fractures are clinically identical, as illustrated in the example below. These should be a rare occurrence.

Example: The patient sustained closed fractures of the shafts of both femurs.
PDX: S72.30 Fracture of shaft of femur, closed
SDX: S72.30 Fracture of shaft of femur, closed
SDX: X59.09 Exposure to unspecified factor causing fracture, during unspecified activity

- Where fractures differ in site, type, or characteristics, each fracture must be assigned a separate, individual code.

PHISC addition to the coding of fractures and follow-up care

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

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

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

Refer to definition of “current injury” and “old injury” (DSN1905 Coding Injuries).

Where the healing process is still ongoing, the coding for open fractures should continue to reflect their initial classification as open, regardless of surgical intervention that may have closed the fractures.

Example:
The patient is status post open fractures of the left tibia and fibula, sustained three weeks prior. He has been immobilized in a long leg cast since the injury. At presentation, he reported no complaints related to the fracture; however, the cast showed significant wear, with breakdown extending along the entire sole of the foot. The long leg cast was removed, revealing intact skin. X-rays demonstrated progressive fracture healing with maintained alignment and no displacement. The patient was transitioned to a short leg walking cast to continue immobilization and facilitate ambulation.
ECC on record V13.49

PDX: Z47.8 Other specified orthopaedic follow-up
SDX: S82.21 Fracture of shaft of tibia, open
SDX: V13.49 Pedal cyclist injured in collision with car, pick-up truck or van, driver, traffic accident, during unspecified activity

🕮 **DSN**1907 **Follow-up care involving removal of fracture plate and other internal fixation device**

Examples added by PHISC

Malunion, nonunion and delayed union

Malunion: union of the fragments of a fractured bone in faulty position[11].
Nonunion: failure of the ends of a fractured bone to unite[12].
Delayed union: a fracture which takes longer than usual to heal.

Example for malunion:
Patient admitted with a malunion of a fracture of the radius. It is now 9 months since the initial injury when treatment started:

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

Example for non-union after the initial healing period of 6 weeks:
Patient went for X-rays to evaluate the ongoing pain of a fracture of the radius, which she sustained 5 months ago. The X-ray indicate the absence of progression of healing and there is still instability at the fracture itself.

PDX: M84.10 Nonunion of fracture [pseudoarthrosis]
SDX: T92.1 Sequelae of fracture or arm
SDX: Y89.9 Sequelae of unspecified external cause code

Delayed union still within the acute phase:
A patient is complaining of ongoing pain to a fractured shaft of the radius, injury sustained 5 weeks ago, when she fell from a ladder at home.
The x-rays indicate slow bone growth, and the doctor is concerned that this may turn to nonunion of the fracture.

PDX: S52.30 Fracture of shaft of radius, closed
SDX: W11.09 Fall on and from ladder, home, during unspecified activity

The injury is still acute as the initial healing period has not passed yet.

[11] Dorlands illustrated medical dictionary, 31st edition.

[12] Dorlands illustrated medical dictionary, 31st edition.

PCS1901 **ICD-10 codes for Human Trafficking**

There are no specific ICD-10 codes for human trafficking. Not all trafficking involves or is related to sexual violence. “The main condition treated” must be assigned as per the primary diagnosis with reference to GSN0001.

Assign a code for the medical condition being treated and a code from **T74 Maltreatment syndromes**. An external cause code must be assigned from **Y07 Other maltreatment** or **Y08 Assault by other specified means** and where applicable codes from chapter XXI Factors influencing health status and contact with health services (Z00 – Z99).

Example 1:
A 21-year-old female presented with a fractured ankle which she sustained two weeks ago at a factory where she works. According to her records, the fracture was not treated as her employer refused any form of medical care. She mentioned that her employer pushed her down the stairs. As per additional information received, an investigation of forced labour is underway at the mentioned factory.

There is evidence that general care has been lacking prior to the current issue. The patient appears neglected. She is very anxious and somewhat depressed. No contact details for next of kin available. It is difficult to get more information as the patient appears to withhold information when questioned.

PDX: S82.80 Fractures of other parts of lower leg, closed
SDX: T74.0 Neglect or abandonment **or** T74.8 Other maltreatment syndromes
SDX: Y01.62 Assault by pushing from high place, industrial and construction area, while working for income

Or

Assign a code from **T74 Maltreatment syndromes** as the primary code and an additional code to identify any associated current injury. An external cause code must be assigned from **Y07 Other maltreatment** or **Y08 Assault by other specified means**.

“The main condition treated” must be assigned as per the primary diagnosis with reference to GSN0001.

Example 2:
An 8-year-old child, malnourished and dehydrated. According to the medical records, the child was found at a factory following a police raid related to a human trafficking investigation.

PDX: T74.8 Other maltreatment syndromes
SDX: E46 Unspecified protein-energy malnutrition
SDX: E86 Volume depletion
SDX: Y07.89 Other maltreatment by other specified persons, during unspecified activity

Or

PDX: E46 Unspecified protein-energy malnutrition
SDX: E86 Volume depletion
SDX: T74.8 Other maltreatment syndromes
SDX: Y07.89 Other maltreatment by other specified persons, during unspecified activity

PCS20 External causes of morbidity and mortality (V01 – Y98)

DSN2001 **External Cause Codes**

External Cause Codes not linked to Injury, poisoning and certain other consequences of external causes

As per the notes in Volume 1 (Tabular List), Chapter XX External causes of morbidity and mortality, it states:
"This chapter, which in previous revisions of ICD constituted a supplementary classification, permits the classification of environmental events and circumstances as the cause of injury, poisoning and other adverse effects.
Most often, the condition will be classifiable to chapter XIX Injury, poisoning and certain other consequences of external causes (S00-T98).
Other conditions that may be stated to be due to external causes are classified in chapters I to XVIII. For these conditions, codes from Chapter XX should be used to provide additional information for multiple-condition analysis only[13]."

There are instructions to provide an ECC for non-injury codes in the volume 1(tabular list)
Examples below:

H26.1 **Traumatic cataract**
Use additional external cause code (Chapter XX), if desired, to identify cause.

H26.2 **Complicated cataract**
Cataract in chronic iridocyclitis
Cataract secondary to ocular disorders
Glaucomatous flecks (subcapsular)

H26.3 **Drug-induced cataract**
Use additional external cause code (Chapter XX), if desired, to identify drug.

External cause code to be assigned for fractured ribs at time of resuscitation

Example:
Patient sustained # ribs during a resuscitation [CPR]

PDX: S22.40 Multiple fractures of ribs, closed
SDX: Y65.8 Other specified misadventures during surgical and medical care

[13] ICD-10 Tabular List, 2010 Edition

Assigning codes Y63.3 (Inadvertent exposure of patient to radiation during medical care) and Y84.2 (Abnormal reaction/later complication, radiological procedure and radiotherapy)

📖 **DSN**1906 **Complications of Surgery and Medical Care**

Example 1:
Patient with lung cancer receiving radiotherapy, developed acute radiodermatitis of the chest 2 weeks after commencement of radiotherapy.

PDX: L58.0 Acute radiodermatitis
SDX: Y84.2 Abnormal reaction/later complication, radiological procedure and radiotherapy
SDX: C34.9 Malignant neoplasm, bronchus or lung, unspecified
*SDX: Add a morphology code if available

Example 2:
A patient with breast cancer is busy with active radiotherapy treatment. During the treatment, the lead shield moved, and healthy tissue was exposed to the radiation treatment. Subsequently the patient developed pain and pruritus of the affected area. Treating clinician confirmed radiodermatitis.

PDX: L58.0 Acute radiodermatitis
SDX: Y63.3 Inadvertent exposure of patient to radiation during medical care
SDX: C50.9 Malignant neoplasm, breast, unspecified
*SDX: Add a morphology code if available

External Cause Codes (ECCs) – Hijacking
The meeting determined that there is no specific code for hijacking but that examples of codes from the ranges Y04, Y08 etc. should be used as the external cause code to indicate the method by which the hijacking occurred.

PHISC addition:
Assign Z65.4 (Victim of crime and terrorism) to indicate that the patient was a victim of a hijacking incident, particularly in cases where no physical injuries were sustained. This code reflects exposure to a traumatic event and should be used to support accurate documentation of psychosocial circumstances.

Example 1 (a):
The patient was hijacked at a traffic light, and her vehicle was stolen. Although no physical injuries were sustained, she presented with emotional distress and shock. Her doctor prescribed medication for her symptoms.

PDX: R45.7 State of emotional shock and stress, unspecified
SDX: Z65.4 Victim of crime and terrorism

Example 1 (b):
The patient continued to experience severe emotional stress. She was diagnosed with acute stress reaction and referred to a psychologist for therapy.

PDX: F43.0 Acute stress reaction
SDX: Z65.4 Victim of crime and terrorism

Example 2:
Patient was hijacked and sustained a superficial injury to hand.

PDX: S60.9 Superficial injury of wrist and hand, unspecified
SDX: Y04.99 Assault by bodily force, unspecified place, during unspecified activity or
Y08.99 Assault by other specified means, unspecified place, during unspecified activity or
Y09.99 Assault by unspecified means, unspecified place, during unspecified activity
SDX: Z65.4 Victim of crime and terrorism

External code for Drone Related Injuries

Assign code **V97.3 (Person on ground injured in air transport accident)** for injuries caused by falling objects, such as packages or debris from drones. This code is considered appropriate for individuals who are not occupants of the aircraft.
An additional fifth-character code is required to specify the activity the injured person was engaged in at the time of the incident.

Assign code **V97.8 (Other air transport accidents, not elsewhere classified)** for injuries resulting from direct impact by a drone. This code was selected to accurately reflect the specific nature of drone-related trauma involving physical contact.
An additional fifth-character code is required to specify the activity the injured person was engaged in at the time of the incident.

 **DSN**2001 **External Cause Codes**

PHISC amendment to "(q) A *bus* is a motor vehicle designed or adapted primarily for carrying more than 10 persons, and requiring a special driver's licence".

In January 2005, the lettering was revised to **"(r) A *bus* is a motor vehicle designed or adapted primarily for carrying more than 10 persons, and requiring a special driver's licence".**

External Cause Codes (ECCs) – Minibus

The definition of a "minibus" as known in SA terms was allocated to definition (n) in the ECC section of Volume 1 of the ICD-10 manuals: "A *car* [*automobile*] is a four-wheeled motor vehicle designed primarily for carrying up to 10 persons".

Definition of "car" as per Public Transport By-law, 2019

- "**motor car**" means a motor vehicle, other than a motor cycle, motor tricycle as defined in the National Road Traffic Act, designed or modified solely or principally for conveying not more than nine persons, including the driver;

This definition includes an Uber or Rixi conveying not more than nine persons.

If more than 10 people are being carried, the definition of the transport vehicle would fall under that of definition (r): "A *bus* is a motor vehicle designed or adapted primarily for carrying more than 10 persons, and requiring a special driver's licence."

The code range V70 – V79.- includes buses that can carry a large number of passengers. The most common type is the single-deck rigid bus for example, Putco, with double-decker and articulated buses

that accommodate even larger loads, midi buses and minibus taxis, commonly used in South Africa to transport smaller groups of passengers.

Definition enrichment for "Taxi" as per Public Transport By-law, 2019

- "**bus**" means a motor vehicle designed or modified to carry more than 35 persons, including the driver;
- "**metered taxi service**" means a public transport service operated by means of a motor vehicle contemplated in section 66;
- "**midi bus**" means a motor vehicle designed for modified solely or principally for conveying more than 16 but less than 35 persons, including the driver and for the purpose of the National Road Traffic Act, is a type of sub-category of bus;
- "**minibus**" means a motor vehicle designed or modified solely or principally for conveying more than nine but not more than 16 seated persons, including the driver;
- "**mini bus taxi**" means a minibus or midi bus used for minibus taxi-type services;
- "**taxi**" means a minibus taxi or metered taxi;

Reference: Public Transport By-law, 2019 - Law Library (Accessed 14/11/2024)

External cause codes to assign for self-inflicted bites

1. Self-inflicted bite occurring as a result of another injury.
If the self-inflicted bite occurred as a result of another injury, assign codes for both the underlying injury and the bite.

Example:
Patient slipped and fell, accidentally biting her lip and spraining her ankle.

PDX: S93.4 Sprain and strain of ankle
SDX: W01.99 Fall on same level from slipping, tripping and stumbling, unspecified place, during unspecified activity
SDX: S01.5 Open wound of lip and oral cavity
SDX: W64.99 Exposure to other and unspecified animate mechanical forces, unspecified place, during unspecified activity

2. Self-inflicted bites occurring while eating or talking.

Example:
Patient accidentally bit her lip while chewing food.

PDX: S00.5 Superficial injury of lip and oral cavity **or**
S01.5 Open wound of lip and oral cavity or
SDX: W64.94 Exposure to other and unspecified animate mechanical forces, unspecified place, while resting, sleeping, eating or engaging in other vital activities

- If related to impaired mastication, assign an additional code K08.8 (Other specified disorders of teeth and supporting structures)

3. Cheek and lip biting associated with mental and behavioural disorders.
If related to a mental and behavioural disorder, assign an additional code F98.4 (Stereotyped movement disorders).

Example:
Patient was noted to exhibit stereotyped self-injurious behaviour involving repeated lip biting.

PDX: K13.1(Cheek and lip biting)
SDX: F98.4 (Stereotyped movement disorders)

4. Lip, tongue or cheek biting during an epileptic seizure.

Example:
Patient accidentally bit his tongue during an epileptic seizure.

PDX: S01.5 Open wound of lip and oral cavity
SDX: W64.99 Exposure to other and unspecified animate mechanical forces, unspecified place, during unspecified activity
SDX: G40.6 Grand mal seizures, unspecified (with or without petit mal)

- Refer to **GSN**0001 **Primary Diagnosis** for all scenarios

PCS21 Factors influencing health status and contact with health services (Z00 – Z99)

DSN2136 Surgery not performed

Surgery not performed

Ensure that the ICD-10 diagnosis code(s) assigned as per DSN 2136 Surgery not performed align with the CCSA code(s) and modifier(s) assigned.

DSN2130 Post Exposure Prophylaxis (PEP)

Coding of PEP for mucosal splashing

Example 5:

A health care worker prescribed PEP following exposure to bodily fluids of an HIV positive patient while working for an income at the hospital. She sustained a splash to mucosal membranes.

PDX: Z20.6 Contact with and exposure to human immunodeficiency virus [HIV]
SDX: Z57.8 Occupational exposure to other risk-factors
SDX: X58.22 Exposure to other specified factors, school, other institution and public administrative area, while working for income
SDX: Z29.8 Other specified prophylactic measures

Example 6:

A health care worker received post exposure management following exposure to bodily fluids of a patient with infectious hepatitis B while working for an income at the hospital. She sustained a splash to mucosal membranes.

PDX: Z20.5 Contact with and exposure to viral hepatitis
SDX: Z57.8 Occupational exposure to other risk-factors
SDX: X58.22 Exposure to other specified factors, school, other institution and public administrative area, while working for income
SDX: Z29.8 Other specified prophylactic measures

Coding guideline for Prophylaxis

Assign codes for prophylaxis as per existing ICD-10 Morbidity Coding Standards and Guidelines document and Z-codes for immunization and vaccination from chapter XXI where appropriate.

Total Parenteral Nutrition (TPN)

There is no specific ICD-10 code for total parenteral nutrition (TPN). Assign a code for the actual condition requiring TPN.

Coding Rehabilitation

DSN2131 **Coding of Rehabilitation**

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

Example:
Patient admitted for rehabilitation of a stroke. Patient presents with hemiplegia and dysphagia.

PDX: I64 (Stroke, not specified as haemorrhage or infarction)
SDX: G81.9 (Hemiplegia, unspecified)
SDX: R13 (Dysphagia)
SDX: Z50.- (Care involving use of rehabilitation procedures)

Coding Convalescence

When a patient is admitted for convalescence, the diagnosis necessitating the recuperation should be coded as the primary code, followed by a code from **Z54 Convalescence** where applicable.

Example:
Frail 95-year-old patient receiving convalescent care following treatment for a hip fracture.

PDX: S72.00 Fracture of neck of femur, closed
SDX: X59.09 Exposure to unspecified factor causing fracture, during unspecified activity
SDX: Z54.4 Convalescence following treatment of fracture

When can Z51.3 (Blood transfusion (without reported diagnosis)) be assigned?

DSN2127 **Transport of Blood**

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

Z51.3 (Blood transfusion (without reported diagnosis)) should only be assigned in the absence of a diagnosis or when there is no reason for the blood transfusion.

The use of Z43.2 (Attention to Ileostomy)

Z43.2 (Attention to ileostomy) is the appropriate code for a urinary ileostomy.

The following ICD-10 codes can be assigned for the malfunctioning of a urinary ileostomy:

- K91.4 (Colostomy and enterostomy malfunction) from chapter XI Diseases of the digestive system (K00-K93) **or**
- N99.5 (Malfunction of external stoma of urinary tract) from chapter XIV Diseases of the genitourinary system (N00-N99)

Confirm details with clinician if you are unsure.

If acute treatment for the cancer is not yet completed
PDX: C67.- [The appropriate bladder cancer code chosen from the various options available C67.-]
SDX: K91.4 Colostomy and enterostomy malfunction **or** N99.5 Malfunction of external stoma of urinary tract
SDX: Z43.2 Attention to ileostomy

If acute treatment for the cancer is not relevant anymore, but the primary problem is the incontinent stoma then:
SDX: K91.4 Colostomy and enterostomy malfunction **or** N99.5 Malfunction of external stoma of urinary tract
SDX: Z43.2 Attention to ileostomy
SDX: Z85.5 Personal history of malignant neoplasm of urinary tract

ICD-10 code to be assigned for the storage of embryos, eggs and semen

Assign Z31.8 (Other procreative management)

Coding guideline for gender re-assignment

Gender reassignment surgery, also known as gender confirmation surgery, typically involves several stages.

Each individual's journey is unique, and the specific procedures and stages can vary based on personal goals, medical advice, and available resources. The essential purpose of transition-related treatment is to therapeutically treat Gender Dysphoria, not to improve a person's appearance.

F64 Gender identity disorders
The treating medical practitioner must confirm the appropriate code from the F64.- range.

The category of Gender Reassignment Surgery includes:
For the **Male-to-Female (MTF)** patient, surgical procedures may include the following:

1. Breast / chest surgery: mammaplasty.
2. Genital surgery: orchiectomy, penectomy, vaginoplasty, clitoroplasty, vulvoplasty, labiaplasty, urethroplasty, prostatectomy.
3. Other procedures: facial reconstruction surgery, electrolysis or laser hair removal, thyroid cartilage reduction, hair reconstruction, voice surgery, liposuction and lipofilling.

For the **Female-to-Male (FTM)** patient, surgical procedures may include the following:

1. Breast / chest surgery: subcutaneous mastectomy, nipple grafts, chest reconstruction.
2. Genital surgery: hysterectomy/salpingo-oophorectomy, metoidioplasty, phalloplasty (employing a pedicled or free vascularized flap), reconstruction of the fixed part of the urethra, vaginectomy, vulvectomy, scrotoplasty, implantation of erectile and/or testicular prostheses.
3. Other procedures: voice surgery, liposuction, lipofilling.

Example 1:
Transgender woman diagnosed with gender identity disorder is admitted for phase 1 (orchiectomy and vaginoplasty) of her gender reassignment surgery.
PDX: Z41.8 Other procedures for purposes other than remedying health state
SXD: F64.9 Gender identity disorder, unspecified

Example 2:
A transgender male diagnosed with gender identity disorder is admitted for final stage (phalloplasty and scrotoplasty) of his gender reassignment surgery
PDX: Z41.8 Other procedures for purposes other than remedying health state
SXD: F64.9 Gender identity disorder, unspecified

Example 3:
A transgender woman is re-admitted for follow up care following breast implant as part of her gender reassignment surgery
PDX: Z42.1 Follow-up care involving plastic surgery of breast
SXD: F64.9 Gender identity disorder, unspecified

Guideline on coding for cardiac devices, with reference to codes Z45.0 and Z95.0

In January 2013, the descriptions of Z45.0 (Adjustment and management of cardiac pacemaker) and Z95.0 (Presence of cardiac pacemaker) were updated to Z45.0 (Adjustment and management of cardiac devices) and Z95.0 (Presence of electronic cardiac devices), respectively.

These updated descriptions are not reflected in the current ICD-10 MIT despite both codes encompassing cardiac devices more broadly and not only cardiac pacemakers.

Extracorporeal membrane oxygenation (ECMO)

📖 **DSN**2141 **Dependence on enabling machines and devices**

The most appropriate code to indicate the presence of ECMO is Z99.8 (Dependence on other enabling machines and devices).
However, it is important to note that this code is not exclusive to ECMO and may also apply to other types of life-sustaining equipment.

Definitions, Acronyms and Abbreviations

Abbreviation	Term / Definition
PHISC	Private Healthcare Information Standards Committee
NDoH	National Department of Health
ICD-10	International Statistical Classification of Diseases and Related Health problems, 10th Revision
MIT	Master Industry Table
WHO	World Health Organization
ICD-11	International Classification of Diseases for Mortality and Morbidity Statistics, 11th Revision