**Third Meeting of the JLMMS Task Force**  
*Cologne, Germany ~ 11-14 April 2016*

### List of Participants:

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<th>External Participants and Observers:</th>
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### Agenda:

1) Welcome  
2) ICD Revision Conference and Project Plan  
3) ICD-11 Business Model  
4) Linearization Naming Conventions  
5) Taxonomy Principles  
   a) Conditions related to sexual health  
6) Shoreline  
7) Primary Care Task Force  
   *** Evening Session: ICD-11 Governance  
8) Generic Coding Rules Update  
   a) Coding Rules  
   b) Exclusion Types  
9) Morbidity Coding Guidelines Update  
10) Mortality Coding Guidelines Update  
11) Chapter Review  
   a) Technical Review of Infectious Chapter  
   b) Technical Review of Skin Chapter  
   c) Technical Review of “Factors” Chapter  
12) *** Side Session: Use Cases  
13) ICD-11 Definitions  
14) ICD-11 Terminology Glossary  
15) Chapter Review  
   a) Technical Review of Neoplasms Chapter  
   b) Technical Review of Injuries and Musculoskeletal Chapter  
16) Functioning Properties Update  
17) Technical Work Packages  
18) Inflammation vs. Infection  
19) ICD-11 Governance Development  
20) Use Cases  
21) Post-2106 Plans  
22) Agenda Planning  
23) National Modifications  
24) DRAFT Meeting Report
1. Welcome

1.1. Background

- The Co-Chairs welcomed everyone present, noting a few absences and late arrivals.
- A primary consideration for the meeting is that the Task Force (TF) has shown repeatedly that work can be done efficiently and well when meeting face-to-face, much better than through remote sessions using teleconferences technology or via mail. The Co-Chairs stressed the need to continue, and to recognize that we must complete a great deal of work during these four days.

2. ICD Revision Conference and Project Management Update

2.1. Background

- WHO provided a brief overview of the volume of work completed since the last face-to-face meeting of the TF in October 2015 (Manchester). Among other things, this included:
  - Briefing report for the executive board: a high level document outlining the key aspects of the new scientific knowledge in ICD-11, the strengths of designing the new classification for modern health care systems and the eHealth environment, improved clinical reporting through the potential for cluster coding, and many other improvements across the classification.
  - Meeting with the Director General of WHO in February 2016: Reiterating the importance of a successful ICD-11 to WHO and increasing attention to the project and the timelines
  - Development of a new Road Map for ICD-11
  - Sharing of a new proposal for Governance of ICD-11 and secretariat functions
  - Specification of a Technical Work Release Plan
  - Preparations for the ICD Revision Conference
  - Drafting of a “business model” around sustainable management of ICD-11 from 2016 to 2018 and beyond
  - Revitalization of the use case specification discussion
- WHO acknowledged that timelines are very short, but recognized the significant work made towards achieving our ambitious goals
  - In support of the huge work load still pending, WHO is increasing the project technical support
- Governance of ICD-11
  - A proposal from Acting Coordinator, DSI / Director, IER, Dr Ties Boerma offers a new way to set up governance around ICD with plans for implementation in 2017. The proposition outlines two new groups, a Medical and Scientific Advisory Committee (MSAC, including previous functions of RSG) and a Classification and Statistics Advisory Committee (CSAC, including previous functions of URC), each tasked with specific aspects of managing and maintaining the classification and foundation.
  - The TOR of the MSAC are to be drafted. The TOR of the CSAC are being drafted.
  - A side-session of this meeting will continue the specifications in a joint effort between the related chairs / co-chairs and WHO with report back to the TF on Thursday.
- Secretariat
  - WHO designated a technical secretariat function to support the work of the TF and other groups in the ICD project and the WHO-FIC Network in an effort to increase communication, transparency, accountability, and successful completion of deliverables.
  - Work by the technical secretariat has focused on collating all previous documentation and communication, arranging and supporting a sustainable calendar of teleconferences including the provision of all required meeting documents with sufficient time for participants to prepare, adequate advanced notice and reminders, and the provision of teleconference notes and meeting reports in a timely fashion, including participant input, in an easily accessible forum for increased transparency.
- Ongoing technical work
  - Some 5200 proposals were received by the deadline of 31 December 2015, the vast majority of which have been processed. New proposals continue to be received at a rate of a few hundred per month.
  - Four chapters have undergone intensive review and have been released to the TF, mbTAG, and mTAG/MRG for review and clearance. Four more chapters will be released by the end of the month, and a release plan for the remaining chapters will be proposed Wednesday (see Technical Work Packages).
- The timeline is ambitious, but is limited by the need to prepare and print the “Release Candidate” for the ICD Revision Conference in Tokyo in October 2016, meaning the technical work must be completed by August 2016.

• Revision Conference
  - WHO is pleased to announce that the Dr Margaret Chan has agreed to attend the Revision Conference and present at the opening ceremony on Wednesday, 12 October 2016.
  - WHO is also working with a communication specialist to develop and share the key messages with Member States and our statistical and clinical colleagues.
  - All WHO Member States will be invited to the Revision Conference, in addition to the WHO-FIC Network. WHO expects to send the invitations by the end of May 2016.
  - WHO is negotiating for a small budget to fund selected Member States with limited resources to attend the Revision Conference, particularly from developing countries.
  - The WHO-FIC Network Meeting will have a more streamlined agenda to accommodate for the Revision Conference.
  - The Japan Hospital Association (JHA) shared additional information about the plans for the combined WHO-FIC Network Meeting and ICD Revision Conference, including a timetable showing all overlapping meetings, and offered thanks to the TF for their work in preparing the ICD-11 MMS version for the conference.
  - Key events for the week include the Mortality Statistics Forum on the afternoon of Wednesday, 12 October 2016. Many excellent abstracts have been received from more than 24 different Member States.

- Revision Conference Agenda
  - The theme will be “Health Information in the New Era”, focusing on consideration of global health data priorities and the role of ICD in these tasks, as well as national priorities for ICD use.
  - The new features of ICD-11, including scientific and informatics advances such as the coding tool and ICD-11 URIs and APIs, will be explained, as well as how ICD can be used as the preeminent health data standard to improve statistics.
  - The Revision Conference will include side events on Traditional Medicine and Internal Medicine, and may also include side events on the advances in the areas of Mental Health Classification, Maternal and Child Health, or other selected topics, time and space permitting.

- Revision Conference Release Package
  - Available documentation will include a conference document with the agenda for the two days and the ICD-11 narrative
  - The package may also include a publication of the ICD-11 “top categories” in print. To distinguish this release from previous work, the colour will be dark blue.
  - “Release candidate” is being considered as a term to describe the version of ICD-11 that will be available for the Revision Conference.
  - The conference package will also be released electronically at the October conference.

2.2. Key Discussion
  - When each chapter is released for review and clearance by the TF, it will be accompanied by a cover sheet which provides an overview of the changes made as well as a list of items where WHO has outstanding questions or requires advice or a solution.
    - In addition, there is a certain amount of additional work required for each before it can be considered “ready for release”, including correcting base index terms, exclusions, grammar, etc.
    - Additional clarity on what the process is for “finalizing” the review of each chapter by the TF is desirable.
  - A question was raised about the impact of shortening the WHO-FIC this year, and if this is acceptable to the Network.
    - The Co-Chair of the WHOFIC Network Council confirmed that the timing is opportune, as there was already a desire to make the Network meeting more efficient, based on feedback from the Heads of Collaborating Centres, meeting hosts, and the Network, in general.
    - Lessons learned in 2016 can be implemented in 2017.
  - A question was raised about the suitability of the phrase “release candidate” for the version of the ICD-11 MMS to be available at the October meeting. Concern was expressed that this term may not adequately manage expectations. Although much has been achieved in advancing ICD-11, and more will be achieved in coming months, the October 2016 release will not yet be sufficiently “final” for implementation. Perhaps a new title for the release could be considered, though this should not include the words “test” or “testing”.
WHO confirmed that we will work with our communication specialist to manage the communication around the October release, and to ensure that we do not over-promise what we can deliver to the Revision Conference.

- A question was raised about the work requested of the TF. WHO is working through each chapter with experts from the TAGs, Network, and others, providing a short-list of issues requiring solutions for each one. Are TF members asked to check all detail of each chapter and to sign off, or just to answer the pending questions?
  - WHO confirmed that the TF is asked to review the questions and help find solutions, at a minimum, and to help identify where there might be issues of major concern.
  - Additional detail review, insofar as time permits, is also welcome and very much appreciated.
- A question was raised about testing, how this might fit into the timeline, and when changes identified from testing will be implemented.
  - WHO confirmed that there will be some limited testing between now and October 2016.
  - After October 2016 there will be additional testing with the feedback incorporated, but how the TF process will work is still being defined. There is a caveat that WHO will be unlikely to consider any “major revolutions” in the classification after the October release, because stability is necessary for the work on mortality rules.

2.3. Action Items

- **WHO** – Consider how best to communicate the October release, both technically and politically, and propose a name other than “release candidate”.
- **TF** – Make all reasonable efforts to ensure that the October release candidate does not have any major weaknesses.
- **WHO and TF** – Prepare a work list coming out of this meeting to see what we have accomplished to date, what we will be able to accomplish for the October release, and what will still be outstanding at the Revision Conference.
- **WHO** – Continue the chapter reviews and provide the updates and coversheets, working (in particular) with the lead reviewers for each chapter.

2.4. Recommendations or Decisions

- The TF notes the ambitious timeline proposed by WHO and raised the concern that this may not be possible. The TF recommends that WHO stay open to additional changes after the October Release if testing and review identifies that such changes are necessary. The TF reiterates that it is more important to have a quality product that is fit for purpose than to rush the publication just to meet a timeline.
- The TF confirms that it will support WHO with the chapter reviews as much as possible, but clarifies that a full, detailed review of all chapters before October release is not possible by this group.

Monday, 11 April 2016 – 11:00

3. ICD-11 Business Model

3.1. Background

- Recognizing that this project relies on a large network of volunteer efforts, WHO needs to evaluate how to ensure sustainable, consistent management and servicing of ICD-11. This business plan originated out of that desire.
- ICD is a public good, services national modifications and commercial interests, and the business model must cater for this.
- Service needs for ICD-11 will be greater, particularly in the area of electronic tools, than previous revisions.
- WHO must balance resources and expectations of, and from, the Network.
- WHO must consider how to manage special interests, such as specialty adaptations, and how to resource support for these.
- Core governance of the foundation and the ICD-11 MMS is key.
- Future work must consider how to manage national modifications, specialty adaptations, and shared intellectual property ownership with modification holders and WHO.

3.2. Key Discussion

- The construct of “ICD for commercial purposes” is a relatively new consideration for the TF, and additional information about what this means or some examples could be helpful.
  - There will be demand from software developers, as there has been for ICD-10, but the expectation is that the demand will be greater and that the current model for ICD-10 used by WHO will not scale up sufficiently.
The use of ICD for reimbursement or other health care performance systems is a major use case, and while it should not drive ICD development, the impact of changes in ICD should be considered.

WHO license fees are an example of a commercial use of ICD, but the scope of licensing for ICD-11 is not yet defined. Will WHO move into the area of providing ICD-11 related applications for use in Member States?

A question was raised regarding the extent of support for the WHO DSI team derived from the sale of ICD print versions and license fees. There was a concern that this might drive the requirement to continue to maintain ICD in a largely print environment.

WHO confirmed that the DSI team does not receive support from the sale of ICD print versions or license fees, and that this is not driving the need to maintain a print version. Rather, the maintenance of a print version is an essential requirement for Member States who do not yet have an eHealth environment. ICD-11 is largely being driven in an electronic health systems environment, and WHO expects to see decreasing reliance on the paper version of ICD as implementation progresses over time in the future.

The global conversation about the use of ICD-11 for public health is less developed at this point than was anticipated, particularly in the area of morbidity use. This is hampered by the separation of WHO and the Global Burden of Disease. How can this be addressed?

There are a trio of issues to address with the business plan – management, governance, and cost.

The TF recommends a model of “core services” that ICD-11 must deliver, which cannot be interrupted by other uses. All other arrangements would be in addition to these core services.

WHO is mandated to produce ICD, namely the foundation and the ICD-11 MMS, and to collect health statistics. The TF recommends that this be delivered without any consideration of revenue generation or fundraising.

Additional services, however, such as APIs, informatics applications, specialty modifications, or other “special” uses requested by specific stakeholder groups may need to include considerations of resourcing.

Further discussion clarified that WHO is not speaking about “resource generation”, per se, rather on cost recovery to ensure that ICD maintenance and support is sustainable.

At this time, no “specialties” or “modifications” should be included in the core services, though there may be some that become so in the future. Additional requests must include identified resources.

The cooperation between WHO and IHTSDO has implications for the business plan. It is agreed that the joint work will continue, but the two Organizations are in the process of updating the mutual agreement and the plans for shared outputs.

The late adoption of ICD-10 by the United States may also have implications on the business model. If there is reluctance to adopt the newer standard by a Member State which represents a major market for health information systems, DRG systems, and other such areas, might other Member States delay implementation, as well?

A TF member raised that Member States have already agreed that WHO must create and maintain the ICD, and that they pay dues in support of this work. They do not want to have to pay “again” for WHO to do the development work, or when it comes time to use it. There was a concern that if WHO licenses ICD content back to a company who develops a product that Member States must pay to use, this also creates a cycle.

WHO confirmed that while the production of ICD is a core mandate of the Organization, the volume of mandated work across WHO and the limited resources essentially means that no team is fully funded to do their work and that additional resources must always be raised to support staff, meetings, etc.

3.3. Action Items

- WHO – continue to clarify what is meant by “commercial purposes / use” of ICD-11, and what the expectations are for the TF.
- TF Members – Develop a list of the “core services” that must be addressed by ICD-11, as well as including other “non-core services” that might be considered in the future, supported by other mechanisms.
4. Linearization Naming Conventions

4.1. Background

- The term “linearization” is not one commonly known to users of ICD. It was suggested to move back to more familiar terminology for existing concepts and to include a glossary clearly explaining new terms.
- Also, there was a desire to shorten some of the acronyms as they can be unwieldy.
- It was suggested to rename the JLMMS, both because it is long and because it contains unfamiliar “jargon” terminology. A list of options for names has been provided for TF consideration and recommendation, particularly ICD-11 MMS (mortality and morbidity statistics) or ICD-11 CSL (common statistical list).
- It was also suggested to return to the convention of “Volume 1, Volume 2, and Volume 3” for the tabular list, reference guide, and index. A new volume, “Volume 4” would represent the foundation.

4.2. Key Discussion

- A suggestion was made to not have the extension codes as a separate “chapter”, as they are not independently codable entities.
  - It was pointed out that the external causes are somewhat similar, and that there is no convention other than chapters for grouping similar entities. The extension codes will therefore remain a “chapter”.
- A comment was made that the phrase “foundation component” gives the impression that the foundation is a subset of the ICD-11 MMS, rather than the other way around. A suggestion was made to call it “the foundation” (more fully, the ICD-11 Foundation) rather than “the foundation component”.
- It was suggested that the special tabulation lists should be an independent volume, or perhaps in Volume 2, rather than in volume 1. No decision was made on this point.
- It was clarified that “Volume 4”, a.k.a. the foundation, is consistent for all of ICD-11 including all linearizations / classifications. However, each linearization / classification will have its own, unique volumes 1-3. There may be overlap, but the tabular list, coding rules, and index will be specific for each.
- Looking further at the Reference Guide (Volume 2), it was noted that section 4.5 – Online tools, needs some additional work. It was suggested to review the section and to offer more clarity on which services are “core” and provided by WHO under the basic budget and which ones are “non-core” and might be associated with additional resource needs.
  - Additional suggestions included to include eLearning tools here, as well as to include a specification that the electronic files for ICD should always be available for Member State use at no cost, as has been the practice historically.
  - WHO clarified that work is already ongoing on defining a Member State package of electronic tools and services.

4.3. Action Items

- WHO – review the section on “online tools” and offer more clarity on which services / web services are “core” versus non-core, as outlined above. Examples are update platform, online index, online coding tool, etc. Also clarify which electronic files are available, the audience, and format, and the mechanism for access.
- WHO – Expand section 4 of the Reference Guide (Volume 2) on ICD Print and Electronic versions to explain that the volume 4 (foundation) is for all of ICD-11, but that there will be unique Volumes 1-3 for each linearization / classification.
- WHO – Change the title of ICD-11 JLMMS to ICD-11 MMS
- WHO – Add a glossary to the Reference Guide (Volume 2) and explain not only new terminology but other key words of ICD (e.g. “underlying cause” or “causal relation”). This may be done through linkages to the relevant sections in the Reference Guide (Volume 2).

4.4. Recommendations or Decisions

- The TF recommends that the title of the ICD-11 JLMMS be changed to ICD-11 MMS.
- The TF recommends that WHO consider not including the extension codes as an independent chapter.
- The TF recommends accepting the other terminology changes as outlined in the Reference Guide (Volume 2).


5. Taxonomy Principles

5.1. Background

- The concept of taxonomy focuses on “where” to put each entity in ICD-11. An example is the determination of each infectious disease, and whether it should go in the infectious diseases chapter or in the relevant body system chapter.
- Any decision may be complicated by factors such as multiple etiologies, ICD legacy or common practice, public health importance, or other issues.
  - For example, items of key public health relevance must be precoordinated to minimize the loss of specificity, but must be balanced with the pragmatism of post-coordination, which offers great flexibility and specificity in a smaller code set, provided it can be implemented.
- Information on this topic has been included in section 3.1 of the Reference Guide (Volume 2).

5.2. Key Discussion

- A question was raised about how discussion on the chapters on “Conditions related to sexual health” and “Sleep-wake disorders” may be relevant here.
- The TF recognized that efforts were made by WHO to ensure that ICD-11 fully covers the precoordinated concepts from ICD-10, but a question was raised about whether ICD-10 codes have been evaluated to determine if (and how often) they are actually used and if, indeed, they need to be covered.
  - WHO confirmed that this has been done for some items and could be expanded, as needed.
  - It was noted that there can be value in including a code that is not used, as there may be value in showing that there are zero deaths due to a given code, e.g. ebola or polio
- A suggestion was made that the consistent application of taxonomy principles across the classification is important, with recognition that it may be necessary to “breach the rules”, but that there must be a good rationale for why it is done.

5.3. Action Items

- **WHO & Statistical Review Group** – Review the available data to determine which ICD-10 codes are not used and the potential pros and cons of maintaining or dropping the unused code.
- **WHO** – Include the taxonomic principles in the Reference Guide (Volume 2).
- **TF** – Use the established taxonomic principles in future reviews of ICD.
- **WHO & TF** – Use the established taxonomic principles to evaluate where and how the entities in the chapters “Conditions related to sexual health” and “Sleep-wake disorders” fit into the structure

5.4. Recommendations or Decisions

- The TF agrees to accept the taxonomic principles as presented and recommends implementing them across all chapters, as much as possible. When it is not possible, the TF recommends that a rationale be required as to why it was not possible and how the solution was reached.

6. Conditions Related to Sexual Health

6.1. Background

- This chapter was created with the aim of reducing the stigma that is sometimes attached to conditions associated with sexual health. However, it is a very small chapter, with only 17 entry level codes primarily located in it, and is not based on the taxonomy of either “etiology” or “body system”, as other chapters are.
- The chapter deals with matters that are politically charged in some contexts and Member States.
- The majority of the entities in this chapter have an acceptable alternate primary location elsewhere in ICD-11 MMS.
  - Of note, if another parent is needed for the entities on Gender Incongruence, they would be placed in the Factors influencing health status and contact with health services chapter, rather than being moved back to the Mental and behavioural disorders chapter (which would imply that they are regarded as diseases or disorders).
- What are the costs and benefits of maintaining an independent chapter for this topic, rather than a special tabulation list?

6.2. Key Discussion

- This is a sensitive topic, but there is also a content issue that requires attention. The solution to one may also solve the other. The TF evaluated the options available for resolving either or both issues.
- As long as each code has a place, alternate solutions can be acceptable. If some entities are moved into the Factors influencing health status and contact with health services chapter, then it may be necessary
to revisit some rules, as this chapter is not used in the same way as the other chapters in certain Member States.

− In certain environments, the factors chapter codes are not accepted as a reason for absence of work.

• The TF does not recommend maintaining the separate chapter, though the TF does want to ensure that all entities are maintained. The TF recommends that categories for Gender incongruence and Female Genital Mutilation should go to the Factors influencing health status and contact with health services chapter, while other entities should return to the most logical position based on etiology or body system.

6.3. Action Items

• WHO – Prepare to remove the Conditions related to sexual health chapter from the ICD-11 MMS, moving the codes that have their primary location in that chapter back to etiological or body system based chapters, where possible, and to the Factors influencing health status and contact with health services chapter where the entity is neither a disease nor a disorder, but may be a reason for encounter.

• TF – Consider what statement the TF would like to make on this decision, should it be questioned.

6.4. Recommendations or Decisions

• The TF agrees that the taxonomic principles should apply to the entities within this current grouping, and that the “Conditions related to sexual health” chapter does not fit the ICD-11 construct for a chapter.

• The TF does not advocate retention of this grouping as a chapter.

• The TF agrees that gender incongruence is neither a disease nor a mental disorder, but recognizes that there will be occasions on which gender incongruence is the reason for encounter with health services and there is thus a reason to provide a codable entity.

• The TF agrees that all entities currently codable in this chapter must remain codable in their new locations to ensure full coverage of the topic.

Monday, 11 April 2016 – 13:42

7. Sleep Wake Disorders

7.1. Background

• The chapter was created through the collection of a group of “complicated” codes from the ICD-10 chapters of “Diseases of the nervous system” and “Diseases of the respiratory system”

• At present, the chapter is seen more as a “syndrome” chapter, including conditions with similar clinical manifestations, but widely different etiologies or involved body systems.

7.2. Key Discussion

• This resolution represents a negotiated compromise agreeable to multiple vertical TAGs.

• Although sleep medicine is a widely recognized branch of medicine that may not have been as widely recognized in 1990 and this may be an argument for such a grouping, this is inconsistent with the ICD-11 taxonomic principles.

• Such groupings may be more appropriately represented as “special tabulations” rather than chapters, though this can be discussed.

• As inclusion of these conditions in the “Mental and behavioural disorders” may result in some perceived stigma, perhaps WHO should consider renaming that chapter to address this issue.

7.3. Action

• TF – Review the chapter carefully, including a thorough consideration of the many codes that include “due to” in the title, or qualifiers such as “child” or “adult”

7.4. Decision

• The TF recommends maintaining the new chapter and reviewing it again after the editing and initial review is completed.

Monday, 11 April 2016 – 13:42

8. Shoreline Document

8.1. Background

• The “shoreline” document will be renamed the “structural review” document.

• The goal of shorelining is to have more consistent depth of categories and more consistent distribution of entities across chapters. Unfortunately, it is not reasonable for us to impose a strict orthogonal theme in each chapter, as there are differences between the different content areas.

• The goal is to agree to the text of the document, as well as to decide whether or not this should be included in the Reference Guide
8.2. Key Discussion

- A suggestion was made that use of existing data is a guide and not a cut-off, as frequency is not the only consideration when determining where to draw the shoreline.
- Shorelining is a task that required line-by-line review, but the taxonomic principles will help guide the review and determining what judgement to make on each entity.
  - mTAG should review which items would cause “problems” for underlying cause statistics (time trends) if not maintained as precoordinated concepts. Lack of a problem may not be rationale to make the cut, but presence of one may be justification to maintain.
  - A potential methodology might be to review all entities at 6+ levels of depth to see if any at that level or below are “necessary”. This should also include a decision that 6 character codes are “undesirable”, and that 7 character and more codes are not permitted.
  - Another potential methodology might be to consider the shoreline axis-by-axis, namely determining which axes are mandatory and which are not for international reporting.
  - Criteria should address the potential problems, such as requiring 5 codes to document something simple, such as a single cause of death.
- The TF suggests that some of the text of the document is suitable for the Reference Guide (Volume 2), but that the majority is useful only now when we are actually doing the work.
  - Some is already included, but not all relevant text.
  - The text should have more information about stem codes vs extension codes, and how the decision is made about what to keep precoordinated.
- The concept of “national modifications” in the text should be reconsidered.
- The use of the phrase “due to” requires strong evidence, and this should be clear in the text. This will require revision of the relevant section in the Reference Guide (Volume 2), 3.6.2.5.
- At present, the text does not address the issues of cluster coding / post-coordination and it must, as must the Reference guide (Volume 2).
- There will be some situations when post-coordination is necessary and this should be documented. Other situations (e.g. specialty use, national modifications, etc.) may require additional post-coordination, and the decisions must also be explained.
- A suggestion was made that a code should always have an etiology and a manifestation, if known, as a minimum. If this combination exists as a precoordinated concept, that should be used. If it does not, post-coordination must be used.

8.3. Action Items

- **TF** – Cross-reference the Shoreline document with the Vol 2 to ensure that all necessary sections are represented in the Reference Guide (Volume 2).
- **WHO and TF** – further develop the language related to cluster coding / post-coordination for the Reference Guide (Volume 2). In particular, this should include specifying when and how post-coordination is mandatory.
- **WHO** – update section 3.2.6.5 of the Reference Guide (Volume 2)
- **WHO** – include text in the Reference Guide (volume 2) about what a stem code is and how it is used in practical terms.
- **mTAG** – evaluate the ICD-11 MMS to determine which codes would cause a “problem” if not precoordinated, as well as looking for any “missing” concepts that will cause an issue.

8.4. Recommendations or Decisions

- The TF agrees that the most current (January 2016) version of the Shoreline document should be maintained as a background document, with future work focusing on development of the content in the Reference Guide (Volume 2).
- The TF recommends that text in the Reference Guide (Volume 2) be developed that clarifies that there will be some mandatory post-coordination for identified entities, but that there may be additional cluster coding used in national or other identified use cases.
Drawing on the list of ICD codes, they have grouped low frequency codes together, while giving high frequency codes their own entries.

Suggestions for how to use the PC classification in PC morbidity settings are available, based on real-world situations.

Often in PC, the diagnosis ends at the symptom level and does not proceed to the formal diagnosis.

An alternate coding structure for the PC classification is proposed, linking to ICD but also unique so the data is not confused. This includes, among other things, a unique set of codes and coding syntax.

9.2. Key Discussion

One suggestion was that, where codes overlap between the ICD-11 MMS and the PC linearization, the codes should be identical, so as to better facilitate transfer of patient records and data between health environments. This might cause some confusion within the PC linearization which may contain some ICD codes and some ICPC codes, each with a unique coding structure.

A concern was raised about different coding systems and the potential that they might not work well together, requiring a patient who moves back and forth between health environments to have multiple codes for the same diagnosis, creating confusion and an additional burden on coders and health systems.

It is possible to have different classifications with different coding schedules connect through the URIs in the foundation. Indeed, this is a key feature of URIs, but for manual users, this is difficult to do.

The issue of easily accessible and available applications was raised, with strong support for creating a mobile application coding tool. There was support for the idea that such applications should be a core service deliverable for ICD-11, though there was recognition that it would be a “new” service with unique requirements for design, maintenance, and resourcing.

Important considerations are whether or not PC will be a unique linearization or a subset of the ICD-11 MMS, and if the telescoping model will be used in the design.

The TF was clear that, whatever the final approach for PC, the technology must ensure that the PC classification does not conflict with the use case of the MMS.

The TF recognized that there are requirements for PC that must be met, but expressed a desire to keep the PC linearization congruent with the ICD-11 MMS.

The foundation was designed to allow for such multiple linearizations/classifications/tabular lists, and can easily accommodate this use case. The TF should therefore not worry about a potential plurality of linearizations drawn from the foundation. Concern should arise when multiple linearizations/classifications/tabular lists are used in overlapping situations, such as in morbidity use in Denmark, Germany, or other countries.

A suggestion was made to test joint use of ICPC and ICD in parallel for health information in a developing country.

The PC task force is optimistic that there will be a large degree of overlap and shared entities between the PC linearization and the ICD-11 MMS. However, it was recognized that, even in an ideal situation, it may not be possible to have complete (or even nearly complete) congruence between the two classifications, and that this may indicate the requirement for an independent PC tabular list.

9.3. Action Items

**PC Task Force** – Consider whether or not the different code set for the different setting is really a workable situation given that patients will move between the PC setting and the Mb setting.

**WHO** – Consider the development of smart phone applications for coding using ICD-11 MMS (or PC linearization).

9.4. Recommendations or Decisions

The TF recommends that effort should be made to create a shared list of entities between the ICD-11 MMS and the PC tabular list, recognizing that implementation of two lists in a single country may have complications.
9.6. Key Discussion

- Looking at products and services associated with ICD-11, WHO must consider the sustainability of the necessary work and support.
- The criteria for including new entities (such as from national modifications) in the foundation is, necessarily, quite low. At the same time, it must be possible to filter out “spam and chaff”
- It is a logical requirement that anything from any modification / adaptation must be in the foundation, first. As such, the barriers to inclusion of an entity from MS into the foundation are low. Inclusion in the MMS, however, has a much higher threshold. The process of how things are added, however, must be specified.
- The working group clarified that the Medical and Scientific Advisory Committee (MSAC) feeds into both the Classification and Statistics Advisory Committee (CSAC) and WHO, rather than just to CSAC.
- When considering the work around traditional medicine (TM), the development has been externally funded. The working group suggested that update and maintenance must be externally funded, as well.
- The working group suggested that the proposal platform should remain open to the public, but that proposal authors should be verified with email authentication and real names on the proposals.
- The desirability of a common ontology was reiterated by the working group, with recognition that this is a new, not always well-understood concept. The working group requested a proposed process for these efforts, and that this work may be part of the MSAC or Informatics and Terminology Committee of the Network (ITC), or both.

- This may also include a discussion about other informatics and architecture components, such as the APIs, web services, etc.
- The working group noted that this proposal focused largely on the processing of proposals updates, and that additional information on overall governance is necessary to complete the paper.
- Each group in the structure should have a clearly defined scope and TORs.

9.7. Action Items

- **WHO** – Develop text around the governance process for the rest of ICD, beyond proposals, including how the rest of the network may be involved and what they will do.
- **WHO and RSG Chair** – Develop text around the informatics aspects of the governance structure to be included in the text. Should include the rationale for why this is important.
- **SW** – Update the text and image for report back at the end of the meeting.
- **MSAC Co-Chairs and WHO** – Draft TORs and a process for how the foundation could be maintained and expanded.

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Tuesday, 12 April 2016 – 9:04

10. Generic Coding Rules Update

### Coding Rules

#### 10.1. Background

- The coding principles for ICD-11 will remain as in ICD-10 in terms of the requirement to code to the greatest level of detail, to code the manifestation and etiology, to cluster code when necessary, etc.
- However, cluster coding in ICD-11 will be more extensive. The concept of cluster coding has been widely accepted, but it is unclear as to the level to which this will be mandated.
- It is also unclear what the final coding syntax will be, though the TF has been provided with a proposal that suggests “\” between codes, with “\\” between stem codes to identify which extensions connect to each stem. (e.g. stem code\extension code\stem code\extension code\extension code)

- This proposal suggests that each “cluster” is for a different diagnosis, e.g. if the patient has diabetes AND a femur fracture, these are different lines (e.g. a carriage return).

#### 10.2. Key Discussion

- An alternate proposal to the carriage return is the numeric cluster mechanism, which was revisited as an option.
  - Some TF members noted that, in some countries, a carriage return indicates a new patient, not just a new diagnosis, and this may, therefore, cause some problems.
  - The requirement for a relational database to include the demographic data was raised, and should be revisited in the context of informatics tasks and the applications WHO may provide.
- The TF noted the pros and cons of the different systems, but showed some preference to have just a single option identified for international reporting. The alternate coding scheme should be included in the annex, however, to provide for different national requirements.
- A question was raised about designation of the main diagnosis, and WHO confirmed that there is an extension code for this use.
A suggestion was raised that the use of “slashes” is a very old IT mechanism, not consistent with newer standards. It was therefore suggested to revisit what might make a better syntax separator.

A suggestion was made that the section of the Reference Guide (Volume 2) that addresses reporting should expand with this additional information, as well as the section on coding.

The TF agreed that the Reference Guide (Volume 2) should include guidance on a simple form of international reporting. In ICD-10, no such standard was provided, and in the vacuum, every system was designed with unique features. The simple standard must recognize that some national situations will already be more elaborate, and in time, the simple version for international reporting may also evolve.

- The standard should be as simple as possible, while still addressing cluster coding, multiple clusters, subclusters, and demographic data.

10.3. Action Items
- WHO – Use the basic description of cluster coding as a given and use this in testing, though the specific separator character to be used is to be determined.
- VdM – Coordinate a group to develop a proposal for the syntax / separator schema. Perhaps HL7 separators, vertical bar, backslash, etc.
- TF – A work group (including JeH, MV, SW, RJ) will develop text about international reporting requirements. If that results in a need to change the current format, that is acceptable.

10.4. Recommendations or Decisions
- The TF recommends that the Reference Guide (Volume 2) outline a simple suggestion for how to use cluster coding for international reporting, recognizing the urgent need for standardization.
- The TF accepts the cluster coding syntax as outlined in the draft Reference Guide (Volume 2) for international reporting, recognizing the potential for changes in the separator used between codes.
- The TF recommends that the agreed cluster coding syntax, with the updated separator character, be used in testing.
- The TF recommends that additional options for coding be explained in an annex to address specific situational or national needs.

10.5. Background
- At present, there are 3 types of exclusions outlined in the Reference Guide (Volume 2)
  - 1 – elsewhere classified, not to be coded here
  - 2 – entity not to be coded here if part of another diagnosis (e.g. depressive episode vs. depressive episode as a part of Bipolar disorder)
  - 3 – not included here, use additional code to fully cover the condition if the given aspect is present
    (in iCAT represented as rule out, also code, and do not code)

10.6. Key Discussion
- The TF noted that, in the current environment, it might be sufficient to just include the “code also” designation, as multiple parenting can address some of the other exclusions.
  - There have been advocates for two exclusion types rather than one
- The TF supported retention of two types, namely a “don’t code it here” exclusion with a link to where the item should be coded and a “don’t code it alone” exclusion with coding guidance about what to also code.

10.7. Action Items
- SW, RJ, and AE – Re-write the section of the Reference Guide to update exclusion types as outlined in the discussion above and circulate to the TF again to ensure it is complete and unambiguous.
- TF – review the updated text and provide feedback.

10.8. Recommendations or Decisions
- The TF recommends using the term “exclusion” only in places where two codes may never be used together. For all other situations currently identified as a type of “exclusion”, the TF recommends using a “code also” notation, or coding hints.
11.2. Key Discussion

• A major issue is that coding guidelines suggest that if a main diagnosis cannot be determined, the most resource intensive diagnosis should be used as the main diagnosis. This is also often difficult to determine, and is often no better than a suggestion to take the “first diagnosis listed in the chart” as the main diagnosis. The TF expressed concern about, essentially, inventing a main diagnosis, but recognizes the long-standing precedent and how difficult this might be to change in some Member States.
  - The TF noted that it is not uncommon to impute missing information, but that in some jurisdictions, such as the United States, there are conventions to flag records where this has been done to note the uncertainty.
  - The requirement to identify a “main diagnosis” is not necessary in all use cases, but is required in many systems using DRGs or similar systems, and it is often driven by reimbursement.

• A concern was raised about ICD-11 effecting established DRG systems, but this was recognized as a necessary part of classification revision. Furthermore, the TF noted that the DRGs are driven by ICD, rather than having ICD decisions driven by specific DRG systems.

• After extensive discussion in the mbTAG and elsewhere, it was agreed that current definition for “main diagnosis”, though not perfect, is the best available solution.

11.3. Action Items

• mbTAG – Add a note to the Reference Guide (Volume 2) about the caveats surrounding the use of “main diagnosis”.
• TF – accept the current main diagnosis definition until such time as a significantly better alternative might be proposed.
• WHO – Update the text in the Reference Guide (Volume 2), particularly around the morbidity coding guidelines, so that it can be understood without re-opening the specific issue of main diagnosis.
• AE & VD – Prepare a list of suggestions for what must be improved in the Reference Guide (Volume 2) and provide comments and suggested edits to WHO
• WHO – Edit the Reference Guide (Volume 2) for language, flow, content, and coherence

11.4. Recommendations or Decisions

• The TF recognizes the necessity of a “main diagnosis” qualifier for statistical and reimbursement purposes, but also notes the need for improvements in this field.
• The TF recommends using the definition for main diagnoses as agreed upon by mbTAG for testing purposes as the best option available at this time.

Tuesday, 12 April 2016 – 11:19

12. Mortality Coding Guidelines Update

12.1. Background

• The mortality rules are more extensive than the morbidity rules, as this use case has been around longer.
• At the same time, the text has expanded on a regular basis with the result that there is a great deal of content to be edited. A key question relates to the level of detail that is required in this area.
• At present, ICD-10 codes are included in the text as “placeholders” until the ICD-11 codes are finally assigned.

12.2. Key Discussion

• Although the length of the text on this topic may be too much, the TF suggested that it was important to consider that users may feel that a section with extensive detail has been replaced with something too generic if too much text is cut.
• The TF recognized that the mortality rules have grown due to the level of ambiguity in ICD-10. This results in “closing the gaps”, but also creates a rule base that is too complex and difficult to use.
• Given that there is a new tabular list, some of this ambiguity may have been addressed, and it could be possible to delete some sections.
  - At the same time, care should be taken to avoid expediencies such as suggesting that an automated coding system might address some issues. The understanding of what happens in the system to reach the conclusion must be included in the text.
• The TF acknowledged that a serious exercise to review and edit the rules is a requirement of moving to a new classification.
• In general, the mortality rules are reasonably acceptable, with the caveats that the ICD-11 codes must replace the ICD-10 codes, and that the rules must be reviewed and edited. If text can be removed, this is desirable, though care must be taken not to introduce new gaps in guidance.
• The TF questioned whether the editing of the rules might effect testing and what the timeline for this editing might be.

12.3. Action Items
• mTAG – Review the mortality coding guidelines to see if there is any additional detail desired, or whether the Reference Guide (Volume 2) can go forward with the current draft.
• mTAG – At the same time as the review above, review the mortality coding guidelines to identify where text is no longer necessary.
• mTAG – Consider whether extension codes are feasible in mortality and how this could work. Examples include how this is done in IRIS, or just for selection of the underlying cause / multiple cause of death coding.

Tuesday, 12 April 2016 – 13:30

13. Chapter Review

Technical Review of the Infectious Diseases Chapter

13.1. Background
• This chapter has been revised with the support of Infectious Diseases specialists. In accordance with the original goal of revision of this chapter, there is a new special tabulation list that allows tabulation by infectious agent. This list will be used for tabulation rather than aggregation purposes, and will not be the primary view for coding.
• All WHO reportable conditions are included in the Infectious chapter.
• The infectious chapter will comprise all conditions where a specific infection has caused illness, and where the fact of being infected is the most important etiological factor of the illness in one organ system or in the whole body.
• Infectious diseases are grouped together by clinical or health prevention, treatment or monitoring tradition (e.g., gastrointestinal infections, multiple-site Candida infections, malaria — the legacy perspective).

13.2. Key Discussion
• The ID working group suggests an organization for diseases of the gastrointestinal system which includes “digestive system disorders (and diseases) of overlapping and unspecified sites” to address the discrepancy in axes between the two chapter structures. The GST WG disagreed with the proposal for reasons outlined in the cover sheet.
• There has been significant detail added to the skin chapter, and as a result there are some conditions that could go into either the skin chapter or the Infectious Diseases chapter. Cellulitis is currently primarily parented to Diseases of the skin, while erysipelas is primarily parented to Infectious diseases. The agreement was to use the hierarchy used in the skin chapter with the conditions removed from certain staph and strep diseases.
• It was also agreed that it made sense for dermatophytosis to be transferred to the ID chapter.

13.3. Action Items
• WHO - Create the new group for Infections of overlapping sites of gastrointestinal tract in the digestive system chapter.
• WHO - Use the hierarchy used in the skin chapter with the conditions removed from Certain staph and strep diseases; move Dematophytosis to the Infectious Diseases chapter
• WHO – Move pneumonia to the Respiratory chapter as a legacy item, but have it also appear in the infectious diseases chapter under multiple parenting and as a specialty tabulation

13.4. Recommendations or Decisions
• The TF agrees that, with the identified changes made and a final verification by the Infectious Diseases Working Group, the Infectious Diseases chapter is accepted as ready for the October Release.

Technical Review of the Diseases of the Skin Chapter

13.5. Background
• The chapter on skin diseases has undergone major restructuring, with the addition of many more detailed entities. The terminology has been updated to be more current. Major changes made to this have come from the fusion of the American, British and German dermatological terminologies.
• Many of the auto generated residual ‘other specified’ have been suppressed. This results in entities that have not been included in the MMS not having a ‘place’ in the classification. (I.e. they are not codable but they cannot appear as index entries under ‘other’ as it does not exist).
• Primary parenting of certain conditions.
  - There are certain developmental skin conditions that either do not have a parent in the Developmental anomalies chapter or have been primarily parented to skin rather than
developmental anomalies chapter. This is in conflict with the etiological structure (convention) of
ICD.
- There are many entities in this chapter that are either signs, symptoms, or clinical forms that have
not been included in the section Symptoms, signs and clinical findings involving the skin. Rather
they have been listed within lists of disease based either on site or etiology.
- There are many entities that have been moved from other chapters (e.g. injuries, mental health, etc.)
into the skin chapter (sometimes with multiple parenting and sometimes without).

- Decisions must be made on:
  - Should the suppressed ‘other’ residuals be unsuppressed if there are so-called “homeless children”
    entities? Or should the children be added to the MMS?
  - On what basis should primary parents be selected for skin diseases and disorders? Should we
    follow legacy of ICD-10 and primarily parent in the original chapter and secondarily parent in the
    skin chapter? OR Leave the primary parent in the skin chapter for specific skin diseases or
    disorders?

13.6. **Key Discussion**
- The TF agreed that the residuals are a big issue that must be addressed, and recognized the different
priorities between the ICD-11 MMS international version and the developing dermatology specialty
adaptation.
- The TF requested that the shoreline be revisited with a more consistent granularity achieved.
- The TF also suggested that the parenting of entities be revisited to be consistent with the taxonomy
principles, as well as legacy practices.
- The TF noted the extraordinary work done in this area by Dr Robert Chalmers and noted appreciation
for his efforts.

13.7. **Action Items**
- WHO – Continue work to review this chapter working with Robert Chalmers and the lead reviewers.
- WHO & TF – Revisit the residuals in the chapter and ensure that these are consistent with the ICD-11
  MMS conventions and taxonomic principles to prevent conflicts or other issues.

13.8. **Recommendations or Decisions**
- The JTF recommends that certain entities moved to the Diseases of the Skin chapter be moved to the
appropriate chapter based on etiology.

### Technical Review of the Factors influencing Health Status Chapter

13.9. **Background**
- Initially, the Functioning Topic Advisory Group for ICD–11 (fTAG) was asked to review chapter 24.
  Input was also received from other TAGs including, infectious, paediatric and injury. A further review
  of the chapter was performed by a small working group from the fTAG following the Manchester
WHO-FIC meeting, 2015. The chapter now has 2 broad categories (ICD-10 had 7):
  - Factors influencing health status
  - Factors influencing contact with the health system
- Revision of the chapter has included:
  - Reorganisation of blocks so that they fall into the two main categories
  - Revision of health status components to align better with ICF concepts and removal of outdated
    and sometimes pejorative language no longer used in community or health services
  - Revision of ‘conditions associated with life style’ to align better with health behaviours in ICHI
- The generic principles of review must apply, but there are no other specific outstanding technical issues.

13.10. **Key Discussion**
- The TJF recognized that this chapter was excluded for mortality use in ICD-10, but that this may not be
  the case in ICD-11. As such, the mTAG is requested to review the chapter.
- A suggestion was made to split the chapter into two different chapters, but this was not accepted.
  - Instead, the TF agreed to change the title for a better fit.
- The TF recognized that this chapter has logical overlaps with primary care, and therefore may be
  considered from that perspective, as well.

13.11. **Action Items**
- mTAG- Review the chapter for utility.
- WHO – Change the title to “Reasons for contact with the health system”, as well as the relevant
  headings.
- PC TF – Also requested to review the chapter with regards to terminology and understanding.
- WHO – Inform the TF with the changes are completed.
13.12. Recommendations or Decisions

- WHO – Change the term “factors” to the agreed upon terminology.
- The TF agrees to the changes identified above, and will review the chapter after these are implemented to see if this chapter can be ready for the October release or if it will need to be revisited.

14. SIDE SESSION: Use Cases

14.1. Background

- A side session was held including Ms Jenny Hargreaves, Dr Christopher G. Chute, Dr Vincenzo della Mea, and Ms Vera Dimitripoulos, as well as Ms Anneke Schmider and Dr Molly Meri Robinson Nicol from WHO.
- Use cases must be clear in order for people to understand what ICD can (and should) be used for as well as how it will work. This will ensure the future of ICD-11 through sustainable development and eventual implementation.
- Previous work has been done to develop a document outlining known ICD use cases, but this work was not sufficiently advanced to serve its purpose at the ICD Revision Conference in October.

14.2. Key Discussion

- A key component of developing use cases is to consider why ICD is important, and for what. This includes reporting of morbidity and mortality statistics, of course, but also much more.
- ICD is important in monitoring progress in the Sustainable Development Goals (SDGs), International Health Regulations (IHRs), reimbursement, scientific consensus of clinical phenotype, public health surveillance, and clinical data aggregation, e.g. metrics of clinical activity, quality management and patient safety, and financial administration including case mix management and resource allocation.
- WHO has historically focused on public health surveillance (mortality and public health morbidity), but clinical use is often more widespread in countries.
  - Clinical collection is where data collection begins, and should be considered in development.
- The Work Group noted that reimbursement may not be a driver of ICD development, but it is a major and very important use case for which ICD is the foundation.
- The work group noted that sometimes the term morbidity is used when hospital admission would be more accurate, and that only approximately 34 countries do ICD coding well, with maybe 70 above the medium quality level.
- The work group agreed that ICD-11 is a flexible, adaptable classification with the potential to serve a wide variety of uses. It is a sensibly organized representation of all diagnostic concepts in health, and serves as a set of aggregating rubrics. It is an integrated classification system to support integrated health care.
- The work group agreed that the document for the Revision Conference is more a strategy and position paper which includes use cases, that emphasizes the value of ICD as a standard in health and the use of the ICD-11 MMS in health information systems for better health information collection and reporting. This should be aimed at health ministers and should explain why ICD is so important and the value of using ICD-11, both independently and as an improvement over ICD-10.
  - This should also address the potential of ICD-11 to serve modern health information needs, and outline the functional applications, resources, and tools that will accompany release to support their implementation in country.
- The work group agreed that implementation is a key message for ICD-11, and that the focus for tech support should be in the development of the API. Tech is a commodity that has a short life span, but API services allow constant evolution of services.
- The work group discussed that ICD-11 may be too complicated to implement on paper, and that if ICD-11 cannot be easily picked up by existing health IT systems, it will not work.
- The work group discussed the potential for how an app could be developed in time for the revision conference, and an open contest could be a very successful mechanism.
- The agenda for the revision conference was raised, and a suggestion was made to clarify the key outcome desired from each section with an overall focus on “health information priorities”, and explaining how ICD-11 does more to help with country needs than ICD-10 did.
  - It was also suggested to ensure WHO gets feedback in every session, with a request to plan for how this can be collected, or a potential stakeholder forum on Friday afternoon.

14.3. Action Items

- WHO – develop new text as a strategy and position paper for ICD-11 which includes some use cases, but which is not limited to the short list contained within. The audience for the paper will be policy makers and health ministers, rather than end users. The paper structure should include:
15.1. **Background**
- Inclusion of definitions is a key “new” deliverable proposed in ICD-11, but there have been some barriers:
  - Definitions take time to draft
  - Some of the definitions proposed are of unacceptable quality
  - Only a low percentage of the definitions at hand at this time are “perfect” and in the desirable, consistent format
  - Additional text increases the cost of printing and the burden on translators

15.2. **Key Discussion**
- It was noted that Member States may not agree with the definitions, even if there is international agreement, as there may be national definitions which are different.
  - Differing local interpretation might be considered a comment in support of standardizing definitions, if the goal is consistent application of the codes.
  - One of the big complaints about earlier versions of ICD was that there were no definitions, and the thresholds, measures, or boundaries of each code were not necessarily clear.
- The TF noted that the process of drafting definitions and of seeking international consensus is key to the potential success of any definition.
- The TF agreed that definitions, if present, should not be long. They should be short, strictly definitional, and provide context and meaning for the category.
  - The TF recognized a difference in how other TF members were using terms such as definition or description.
- The TF noted that, even if definitions are present in the classification, coders are still limited by the documentation of the provider as they are not authorized to “interpret” the notes. It should be recognized that, even with definitions present, the code represents “what the provider wrote” rather than as representative of “what the patient has”. This has always been the case, but may require a note that the definitions may be used to help the coder choose the correct code, but may not be used to override what has been documented by the provider or on the certificate.
  - The TF recognizes that there is no guarantee that the provider will be using the diagnosis in accordance with the definition
- The TF acknowledges that different clinicians around the world may use terminology differently and there may be discrepancies in diagnostic skill between providers. However, this is something specifically for WHO to address, and definitions represent an effort to increase consistency and comparability between the rubrics of ICD, making the classification stronger.
- There was a broad opinion that the ICD definitions could define the category, and not the named disease, per se, with specific dissenting opinions. The TF must further discuss the “scope” of the definitions.
  - It was recalled that one of the big items for ICD-11 was to help clinical decision making, and to be fit for multiple purposes. If a specific Member State decides not to include the definitions in their national modification; that is a separate issue.
- The TF agrees that to print the definitions would increase cost unreasonably and make the text too large. As such, the decision is made not to include the definitions in the print version in October, and to discuss in the future whether the definitions should ever be included in the print version of the ICD-11 MMS, or only be available through the electronic version.
- The TF recognizes that WHO did produce criteria and guidance for drafting a “good” definition, but agreed that this was produced too late in the process and that not all definitions yet comply with this...
standard. In particular, the guidance states that the definition should be short and include only the information which is absolutely, always true (e.g. pancoast tumor is always in the lung) and not just “nice to know”.

- In situations where WHO has developed a definition for a given disease through their established process, this should be put into the consistent format and respected. These are rare, however, and in other cases, definitions were written by individuals drawing upon their own information, expertise, and a variety of other sources.
- The TF was concerned about how WHO might get international consensus on the definitions, particularly in light of limited resources, and how conflicts of expert opinion might be mediated.
- The TF was also concerned about the resources available for continued improvement and maintenance of definitions by WHO.
- The TF was not able to come to agreement on what definitions are, therefore, could not make a final decision with regard to definitions in the ICD-11 MMS at this time.
- The TF agreed that the definitions in the foundation are under the responsibility of the RSG (soon to be replaced by the MSAC)

15.3. Action Items

- **WHO** – Do not include the definitions in the release candidate of the MMS that will be printed in hard copy for October.
- **TF** – plan for future considerations, such as deciding what the definitions will be and how they will be used and maintained in the future
- **TF** – Consider the two types of definitions in the reference guide – perhaps revisit these and clarify how each relates to the other.
- **CC and UV** – discuss a plan for definitions and draft text for consideration by the TF and WHO.
- **TF** – Revisit the issue in the future with regard to including the definitions in the print or just in future digital versions of the ICD-11 MMS.

15.4. Recommendations or Decisions

- The TF recognizes that there is disagreement regarding the purpose of definitions, and that this should be clarified before the ICD Revision Conference in October.
- The TF recommends that WHO not include the definitions in any print version given the associated increase in size and cost of printing.
- The TF suggests that a more detailed discussion about the maintenance of definitions must be held, particularly in light of limited resources, while recognizing that additional work is needed here.
- The TF recommends revisiting this topic after the plan developed by CC and UV is available.

**Wednesday, 13 April 2016 – 10:03**

16. ICD-11 Terminology Glossary

16.1. Background

- Given the volume of new terminology around ICD-11, WHO has prepared a sample glossary in the Reference Guide (volume 2) with very rough definitions. Both the term list and the definitions are provided only to stimulate discussion and cannot be considered final.
- WHO is asking if there is sufficient need to justify a glossary, and what format this should take (e.g. all specific terminology, just new terms, text definitions of terms or hyperlinks to the relevant sections, etc.
- WHO is also asking if there are additional terms that should be defined.

16.2. Key Discussion

- The TF agreed that a glossary provides a useful “at a glance” format of specific terminology that can be useful to both experienced and new coders, alike. This also recognizes that individuals may not read the Reference Guide (Volume 2) in a linear format, making a glossary at the beginning very beneficial.
- The TF agreed that links to and from the glossary to the use of the terms in the Reference Guide (Volume 2) would also be useful.
- The TF suggested to have a reviewer familiar with ICD-10 but not involved in ICD-11 review the glossary for clarity and additional suggestions.
- The TF suggested that all jargon / specifically used terminology in ICD-11 should be included in the glossary.
- It was also suggested that the glossary be reproduced / used in training tools for consistency.
16.3. **Action Items**
- **WHO** – Maintain the glossary in the Reference Guide (Volume 2), though options are flexible for how this will be represented. This would be a full glossary, not just new terms.
- **TF** – Offer a list of terms that are essential for the glossary.
- **TF** – Identify a reviewer with ICD-10 experience but not ICD-11 experience to give feedback on the glossary.
- **WHO** – Include glossary in the Revision Conference package of information.

16.4. **Recommendations or Decisions**
- The TF recommends including a glossary including all terms that users of ICD-11 need to understand, not just new ICD-11 terminology.

### Wednesday, 13 April 2016 – 10:14

#### Chapter Review

**Technical Review of the Neoplasms Chapter**

17.1. **Background**
- The chapter has been updated with information from other standards and classifications, and WHO notes the active choice to design a structure with competing axes in the high-level organizational structure.
  - The rationale for having an anatomy axis (e.g. brain) on the same level with tumour activity (e.g. malignant and benign) was that tumours in the brain are often fatal, regardless of whether they are malignant or benign, making this split clinically relevant.
- Remaining questions include whether or not the chapter is complete, if the shoreline is appropriate, and if any issue among the residuals remains.

17.2. **Key Discussion**
- The concept of “overlapping lesions” in ICD-10 was used when the site was not clear. The phrase has not consistently been used this way in ICD-11, and it is not clear if this was intentional or an oversight. Available information indicates that this was an oversight.
- Two groups, the NPM TAG and the GST Working Group do not agree on preferred terminology, with one group advocating the use of “neuroendocrine neoplasm” and the other preferring “carcinoid and other tumour”.
  - The TF considered clinical use and consistency with terminology in the IARC blue books and ICD-O.
  - The TF notes that WHO recommended changing to “neuroendocrine” in 2010, but suggests using carcinoid as a synonym and inclusion term.
  - The NPM TAG has requested the addition of a new concept for “Neoplasm of uncertain behaviour of appendix”, though the GST WG suggests that this concept overlaps with malignant neoplasm of the appendix.
  - The TF looked at existing terminology and suggested the addition of the new term in the suggested location, as malignant neoplasm of the appendix already exists under the malignant axis.

17.3. **Action Items**
- **WHO** – Develop a coding guideline that directs coders to use the “ill defined site” option when an issue of clarity among overlapping lesions arises. Include the term “overlapping site” as an inclusion in each of these instances.
- **WHO** – Use “neuroendocrine” as the terminology in the preferred term, but include carcinoid as a synonym for clinical utility.
- **WHO** – Create a new concept of “Neoplasm of uncertain behaviour of appendix”

17.4. **Recommendations or Decisions**
- With the changes noted above, the TF recommends that the Neoplasms chapter is ready for the October release.

#### Technical Review of the Diseases of the Injuries and Musculoskeletal System Chapters

17.5. **Background**
- The review was primarily from the perspective of injuries, including the areas that overlap with the musculoskeletal chapter.
- As this meeting has only recently ended (e.g. the day before the start of this meeting), many of the decisions made are still pending implementation.
- The goal is to have these two chapters released by 29 April.
- An overview of the decision made includes:
  - Cutaneous injuries will return to primary parenting in the injuries chapter.
A definition of injury was discussed at the meeting, and this was put into practice to facilitate determination of primary parent for many concepts.

Coding guidance will suggest using the extension code for multiple fractures with instructions to code each individual fracture for morbidity purposes.

A coding rule is necessary to guide use of post-op haemorrhage and haematoma.

A decision to review what detail from the extension codes will be mandatory for international reporting.

As a result of the changes done (and pending) in the injuries chapter, many (or all) of the 7 character codes will disappear.

17.6. Key Discussion

Multiple parenting is used extensively in the MSK chapter. This may be limited to specific ‘is_a’ relationships.

- An example is that Congestive Heart Failure may reasonably be multiple parented into a variety of categories.

There is a clear need to update the substances list – the structure may remain the same, but the extension code list should be expanded to include additional items.

Mapping between ICD-10 and ICD-11 may be useful to mitigate any potential gaps or loss of information.

A proposed title change to the MSK chapter was well-received by the TF.

Pending issues include:

- Anaphylaxis, with a request for mTAG to review this from their perspective.
- Careful determination of which specific codes may be used for underlying cause and which may not.
- A decision on rheumatologic conditions.

The TF agrees, in large part, with the decision made, but has not yet had sufficient time to review the work and acknowledges that some specific issues remain, and therefore does not yet sign off on these chapters.

It was suggested by one TF member to consider changing the title of the chapter from “Diseases of the musculoskeletal system and connective tissue” to “Musculoskeletal system, soft tissues, and systemic autoimmune diseases”.

As encoding of drug related death will change with the new structure it was noted that a careful review of these cases is necessary before a final decision. mTAG will have to take a close look.

17.7. Action Items

- **WHO, TF, MSK and IEC Working Group** – Develop cross-walks between ICD-10 and ICD-11, working with mTAG, OECD, etc. for all ICD entities.
- **WHO** – Consider renaming the “Diseases of the musculoskeletal system and connective tissue” Chapter “MSK, Soft Tissues, and Systemic Autoimmune Diseases”.
- **MSK and IEC Working Group** – Continue to work on the question of which extension codes are mandatory for international reporting.
- **mTAG** – Review the section on anaphylaxis.
- **mTAG** – Review coding of drug related death.
- **TF** – Review the substances list for necessary additions.

17.8. Recommendations or Decisions

- The TF recommends additional work be done on the entities titled “anaphylaxis due to . . .” to ensure that they are fit for the mortality use case.
- Non-organ specific systemic autoimmune diseases (NOSSADs) will be parented into the “Disorders of the immune system” chapter.
- The TF agrees with the proposed changes, and will revisit the immune and musculoskeletal chapters after implementation before confirming that the chapters are ready for the October release.
coded in parallel. This position represents true dual-use of ICD and ICF, each as an independent classification requiring adherence to its own coding rules, but with all necessary codes from both classifications assigned to the health record of a case. This approach holds that FP values and ICF codes are synonymous and interchangeable, while respecting the integrity of the ICF model.

- Functioning properties in ICD-11 are unique to ICD-11. While remaining linked to ICF categories, the ICD-11 FPs are not the same as ICF. The ICD-11 FPs may be used to further describe the relevant activity and participation aspects of a health condition, in a model that is similar to the use of signs and symptoms to more fully describe an ICD entity. ICD-11 Functioning Properties are the value set to be used when populating the FP parameter of the ICD-11 content model for each specific ICD diagnosis. These ICD-11 FP values may be mapped to ICF concepts to support data comparability, but do not duplicate the ICF, as they serve a different purpose and are used in a different way. ICF codes and titles are provided in the ICD-11 FP list to provide a possible reference to the ICF source from which they are derived with recognition that ICD cannot be used to code ICF concepts. This model continues to allow dual-coding of records with ICD and ICF, as has been encouraged for the past 15 years. It also provides, as an alternative, the option of ICD-11 FPs. This can be seen as an intermediate step, with potential to increase awareness of functioning concepts and of the potential to include some standardized functioning information in health records in settings in which use of the full ICF is either difficult or undesired.

- There is merit in both perspectives on joint use of ICD and ICF, and on functioning properties.
- ICD-11 MMS currently reflects the second of these positions, and is intended to implement a compromise developed in a WHO meeting from February 2010, chaired by Dr Richard Madden, including experts from the WHO-FIC Network as well as other ICF experts from both within and outside of WHO. In its present form, the implementation is the result of many iterations and extensive feedback. It is not yet considered “final” however, and additional input is still actively being sought.

### 18.2. Key Discussion

- It is not evident how the ICD-11 MMS could simultaneously satisfy both positions. However, decisions must be made by the TF and WHO on what will be in the ICD-11 MMS on the matter of functioning properties. Most urgent is to decide what will be in the version of ICD-11 MMS that will be prepared for the Revision Conference. That decision must be made by August 2016, at latest.
- The TF questioned whether or not there was sufficient expertise in the room to address the content issue, noting that the issue was not about ICD-11 as such, but rather about potential conflict associated with the use of an “ICF short list” in ICD-11. It was suggested that, perhaps, there are two ways of using ICF in relation to ICD and that perhaps this could satisfy both positions.
- The TF clarified that the question is multipartite, namely:
  - Given that functioning properties will remain in the foundation, the question for the TF is whether or not to include this parameter in the ICD-11 MMS.
  - If FPs will remain in the ICD-11 MMS, there must obviously be coding guidance in the Reference Guide (Volume 2) to guide their use.
  - Previous decisions to include only titles and high level categories in the October release print version already addresses the issue of whether or not FPs may be printed in the text – they will not be.
- The TF recognizes that FPs are a bridge to better awareness of functioning information and that this has value. The TF sees potential for using ICF concepts or FPs in the ICD construct, but also that there is some disagreement on how best to do this.

### 18.3. Action Items

- RSG-SEG – to be asked to evaluate the coding guidance text as well as the available information and recently received feedback, speaking with stakeholders as necessary, to come to resolution on the draft coding guidelines.
- TF – Await decision by the RSG-SEG, then assess its implications for the ICD-11 MMS
- WHO – Based on the information from the RSG-SEG and TF, either include the updated FP coding guidance in the Reference Guide (Volume 2) or develop suitable placeholder text for consideration by the TF.

### 18.4. Recommendations or Decisions

- The TF sees potential in enabling use of functioning information in the ICD-11 MMS, but recognizes that there are outstanding issues. On the basis of the available information, the TF cannot make a recommendation on whether to retain or change the current approach to functioning that is in the ICD-11 MMS.
- The TF recommends that the RSG-SEG fulfil the function of mediating between TAGs with a request that the TF be informed of the outcome to allow a better understanding of how to move forward.
While the TF recognises that RSG-SEG will manage the request as it sees fit, the TF anticipates that RSG-SEG will consult with the fTAG, among others. Accordingly, the TF recommends that individuals who have views on the matter should submit these formally to the fTAG and RSG-SEG for consideration and deliberation.

No later than the end of August 2016, the TF will advise WHO on the inclusion of functioning properties in the version of ICD-11 MMS that will be provided to the Revision Conference.

In the event that resolution is not reached, a placeholder will be inserted advising that coding guidance for functioning properties is in development.

The TF reiterates that they would like to see a positive resolution on this difference of opinion.

Wednesday, 13 April 2016 – 13:10


19.1. Background

A detailed timeline was developed based on working backwards from deliverable date at the end of August, with a review of how much work was needed for each chapter to review, and a proposed timeline for release.

Each chapter release will include a list of specific questions and some general questions about the shoreline, exclusion and inclusion terms, etc. for review by the TF.

The general plan for release is as follows:

- March
  - Chapter 01 – Infectious Diseases
  - Chapter 02 – Neoplasms
  - Chapter 15 – Diseases of the Skin
  - Chapter 24 – Factors influencing health status and contact with the health system
- April
  - Chapter 11 - Diseases of the ear and mastoid process
  - Chapter 12 – Diseases of the circulatory system
  - Chapter 16 – Diseases of the musculoskeletal system and connective tissue
  - Chapter 22 – Injury, poisoning and certain other consequences of external causes
  - Chapter 25 – Codes for special purposes
- May
  - Chapter 03 – Diseases of the blood and blood-forming organs
  - Chapter 04 – Disorders of the immune system
  - Chapter 06 – Endocrine, nutritional and metabolic diseases
  - Chapter 17 – Diseases of the genitourinary system
- June
  - Chapter 07 – Mental and behavioural disorders
  - Chapter 13 – Diseases of the respiratory system
  - Chapter 18 – Pregnancy, childbirth and the puerperium
  - Chapter 19 – Certain conditions originating in the perinatal period
- July
  - Chapter 09 – Diseases of the nervous system
  - Chapter 10 – Diseases of the eye and adnexa
  - Chapter 14 – Diseases of the digestive system
  - Chapter 20 – Developmental anomalies
- August
  - Chapter 21 – Symptoms, signs, clinical forms, and abnormal clinical and laboratory findings, not elsewhere classified
  - Chapter 23 – External causes of morbidity and mortality
  - Chapter 26 – Extension Codes
- September
  - Final preparations for the ICD Revision Conference

19.2. Key Discussion

The TF requested clarification regarding the amount of effort that will be needed to review each chapter in this and in any future iterations as well as the process for “signing off” on the reviews. They also asked about the necessary “lag time” between completing the review and implementing the agreed changes.
• The TF was concerned that the timeline is, perhaps, a bit too ambitious and may impact negatively on the Revision Conference.
  − WHO clarified that the deadline of the Revision Conference is immutable, and though there can be some flexibility in some areas, it will be important to receive feedback on chapters during the specified review period, as it may not be possible to revisit each chapter repeatedly if the deadlines are to be met.
  − The TF suggested additional teleconference to help handle the workload, and also that another face-to-face meeting during the month of July may be necessary.
• The TF raised a question about the title “release candidate”, and what this implies. Clarity was requested about how “final” this version would need to be, and how results of testing might be accommodated.
  − WHO confirmed that changes can still be made after October, but that the October release should be solid, stable, and without many “deep” errors, and that it was unlikely that any major “revolutions” could be considered after this time.
  − The TF raised a concern that the reputation of the project might be damaged if the version was presented as more “final” than it really will be.
• The TF agreed to assign a pair of “lead reviewers” to each chapter to ensure feedback can be received. All TF members are welcome and encouraged to provide feedback, but the lead reviewers are responsible for checking for major flaws.
• The TF agreed to dedicate significant amounts of the time on the existing monthly teleconferences to checking off the issues and finalizing chapters, and to table any issues that cannot be settled for the face to face meeting.
• An additional teleconference with the lead reviewers of each chapter will be set, as needed.
• The process, generally, will be as follows:
  − WHO sends out the chapter
  − Lead Reviewers and interested TF members will complete their review within two weeks
  − The results will be finalized on the following TF TC (approximately 3 weeks after each release)
  − The chapter will either be signed off for October or tabled with the specific pending issues for the face to face meeting identified.

19.3. Action Items

• WHO – manage the communication around the Revision Conference Release to ensure that it is clear that this is ready for testing, but it’s not “final”.
• TF & WHO – work on a “1 pager” listing what is done and what still needs to be done for the Revision Conference. This text should be included in the Use Cases document (a.k.a. Strategy and Position Paper)
• WHO – complete the work on each chapter, prepare the cover sheet, and release the chapters according to the established timetable.
• WHO – Schedule the additional teleconferences with lead reviewers, as needed
• TF – divide up the chapters, acting as "lead reviewers" in a pair for each chapter.
  – Ch. 1 – Infectious Diseases (done)
  – Ch. 2 – Neoplasms (done)
  – Ch. 3 – Blood (Martti Virtanen and Ulrich Vogel)
  – Ch. 4 – Immune System (Jenny Hargreaves and mTAG)
  – Ch. 5 – Conditions related to Sexual Health (to be removed)
  – Ch. 6 – Endocrine (Kaori Nakayama and Vera Dimitroupolos)
  – Ch. 7 – Mental Health (Ulrich Vogel and Lars Berg)
  – Ch. 8 – Sleep-Wake (Ulrich Vogel and Anne Elsworthy)
  – Ch. 9 – Neurology (Bob Anderson and Ulrich Vogel)
  – Ch. 10 – Eye and Adnexa (Ulrich Vogel and James Harrison)
  – Ch. 11 – Ear (Solvejg Bang and Vera Dimitroupolos)
  – Ch. 12 – Circulatory (James Eynstone-Hinkins and James Harrison)
  – Ch. 13 – Respiratory (James Eynstone-Hinkins and Anne Elsworthy)
  – Ch. 14 – Gastrointestinal (Kaori Nakayama)
  – Ch. 15 – Skin (Stefanie Weber)
  – Ch. 16 – Musculoskeletal (James Eynstone-Hinkins and mTAG)
  – Ch. 17 – Genitourinary (James Eynstone-Hinkins and mTAG)
  – Ch. 18 – Pregnancy, Childbirth, and the Puerperium (Bob Anderson and Vera Dimitroupolos)
  – Ch. 19 – Perinatal / Neonatal (Bob Anderson and Anne Elsworthy)
  – Ch. 20 – Developmental Anomalies (Stefanie Weber and Jenny Hargreaves)
  – Ch. 21 – Signs and Symptoms (Lars Berg and Kees Van Boven)
  – Ch. 22 – Injuries (Bob Anderson and mTAG)
  – Ch. 23 – External Causes (James Eynstone-Hinkins and mTAG)
  – Ch. 24 – Factors influencing health status (Kees Van Boven and Jenny Hargreaves)
  – Ch. 25 – Codes for Special Purposes (unnecessary to review)
  – Ch. 26 – Extension Codes (Vincenzo Della Mea, for technical implications/presentation)
19.4. Recommendations or Decisions

- The TF recognizes that the goal of an almost final ICD-11 for the Revision Conference is very ambitious. Given the recommendation of the TF Co-Chairs from the January 2016 meeting in mind, this new timetable puts even greater pressure on the team of reviewers.
- The TF recommends allowing for sufficient checking and testing before declaring that ICD-11 is “final”.
- The TF offers to help as much as possible, given limited time and resources available within the group, but clarifies that not all flaws and errors can be detected in such short timeline.
- The TF suggests that the name “Release Candidate” is not the best option for the October release and recommends that this be changed.

Wednesday, 13 April 2016 – 15:10

Inflammation vs. Infection

19.5. Background

- The observation was raised that some TAGs have used the term “inflammatory” as the antonym to “infectious”. This has not been done consistently, and the chapters under the GURM TAG are noted exceptions.
- The suggestion was made that, with the exception of pelvic inflammatory disease, the term “inflammatory” should not be used to define an infectious process.

19.6. Key Discussion

- The TF noted that, although there is elegance to such a binary option, the term “inflammation” is an overarching term which represents the cellular response and may be due to processes that are either infectious or non-infectious.
- The TF noted that this might be a good example in favour of definitions / descriptions, as the entity should be clear about whether or not an infectious agent is responsible for the inflammation. This excludes those conditions where the presence or absence of infection is neither known nor specifically relevant.
- The TF raised the concern that this might be presently used incorrectly, with the implication that inflammatory conditions cannot be infectious, and that perhaps this should be looked at from the other perspective.
- The TF confirmed that they would like to have the term “inflammation” used correctly and consistently across the classification. If inflammation is used to mean “infection”, this should be corrected. If inflammation is used to mean “never infection”, this should be corrected, as well.

19.7. Action Items

- TF and WHO – Include a review of the use of the terms “inflammatory” and “inflammation” in the chapter reviews.

19.8. Recommendations or Decisions

- The TF recommends that genitourinary chapter is in need of additional review.
- The TF recommends that the term “inflammatory” be used consistently throughout the classification, not as a synonym of “non-infectious”, but rather as a parent of “infectious”.

Monday, 11 April 2016 – 16:05 and Wednesday, 13 April 2016 – 15:26

20. National Modifications

20.1. Background

- Text related to national modifications was proposed in section 10.3 of the Reference Guide (volume 2) for consideration by the TF.
- This text states that national modifications must follow the “telescopic principle” of development, leaving the ICD-11 MMS untouched but additional detail below the level of the MMS through precoordination or mandated post-coordination. The text also states:
  - If a national modification holder does not agree with a given code from the ICD-11 MMS, they must submit a proposal for change to WHO and may not simply decide to make a local change.
  - If a national modification adds additional detail or new entities not from the foundation, the national modification holder must report this to WHO so it can be included in the foundation and considered for potential inclusion in the ICD-11 MMS international version.

20.2. Key Discussion

- The TF noted that there are two primary perspectives, with pros and cons for each:
Let the national modification holders do whatever they please, but require changes and additions to be reported back to WHO.

Require that the national modification holders submit changes or additions to WHO first for inclusion in the foundation, after which the entity may be drawn into the national modification.

- In either case, it is essential to have countries report their modifications back to WHO, though the exact mechanism for this reporting is still to be defined.
- The TF confirmed that all national additions must be included in the foundation. If conflicting definitions or entities are submitted, WHO should mediate the conflict with the support of the MSAC.
- The TF recognized that previous methods had resulted in a proliferation of slightly different methods of coding the same concepts, and suggested that using the foundation for all national modifications may help to address this. At the same time, it will remain important to respect national autonomy.
- The TF confirmed that additions to the foundation may or may not be included in the ICD-11 MMS international version.
  - The TF questioned the timeline of adding items to the foundation, as national modifications will have their own timelines.
  - The TF recognized that, while it may take a year or more to add something to the ICD-11 MMS, the threshold is lower and the timeline shorter for adding items to the foundation.
- The TF confirmed that international comparability is highly desirable, but that national modifications must serve the needs of the country or ICD-11 will not be used.
- The TF agreed to an in-principle desire to have international comparability and agreement. There was concern, however, about the extent to which this can be pragmatically achieved while still allowing national requirements and timelines to be met. This requires balance between comparability at the international level and flexibility at the national level.
- The TF confirmed that countries should be encouraged to use the ICD-11 MMS international version if at all possible, and that national modifications are not desirable.
- The TF specifically articulated a desire for harmony among national modifications, where possible. As such, countries should be encouraged to draw their additional concepts from the foundation.
- The TF suggested asking countries to review the ICD-11 MMS and propose how this might service their national modification needs. Items to be addressed should include whether post-coordination will be used and to what extent, whether the existing foundation addresses their national needs, and for a list of what concepts might be required that are not currently available through the foundation. This is something of a wide-spread stability analysis exercise.
- The TF noted that the text in the Reference Guide (Volume 2) is underspecified and encouraged further specification about the level of granularity and mandatory post-coordination that will be included in the ICD-11 MMS international version.
- The TF recognized that post-coordination allows for the addition of nearly infinite additional concepts, and that it is likely that post-coordination would more than cover nearly all of the concepts that might exist in a national modification version.
- A question was raised that, while the TF has primarily focused on national modifications which add additional detail, there may be national modifications which seek to create a less-detailed version. This idea must be further explored.

### 20.3. Action Items

- **SW** – Update the text on national modifications in line with the comments above, namely that use of the ICD-11 MMS international version is the preferred version of ICD-11 for MMS use, that proposals should be submitted to update the ICD-11 MMS and/or foundation if new concepts are desired, and that all concepts in any national modification must be drawn from the foundation.
- **WHO** – Share the African technical strategy with the TF to inform further conversations about less-detailed versions of ICD-11
- **TF Co-Chairs** – Table this topic until after the Revision Conference.

### 20.4. Recommendations or Decisions

- The TF noted that national modifications are not part of the discussions around the ICD-11-MMS, though the ICD-11-MMS may influence, or be influenced by, how they will be handled.
- The TF confirms that the discussion on national modifications went as far as this group can take it, and recommends to leave the topic and only to revisit it if new aspects relevant for the ICD-11-MMS emerge.
21.1. **Background**
- A proposal was made by Dr Ties Boerma about a new governance structure for ICD-11.
- This proposal was discussed in a side session by the chairs and co-chairs of the different groups this week and has been updated.
- The proposal is still in draft form and comments are welcome.

21.2. **Key Discussion**
- The TF noted that there is both a governance structure and a proposals workflow in this document and the overlap is a bit unclear.
- Among other things, the TF would like clarity about where the Collaborating Centres fit within the structure.
  - WHO confirmed that the CCs would most likely fall within the CSAC, as this is the evolution of the URC, with other groups, for ICD.
- The Primary Care Task Force representative suggested that the structure should include a PC reference group in addition to those for morbidity and mortality.
  - The TF agreed to include PC expertise within the morbidity reference group, rather than adding another reference group, to better align shared interests. This is preferred rather than having a proliferation of groups that must all be reconciled at the end.
- The TF noted that a “moderator” level will be necessary in lieu of a “compilation of proposals” layer, as more work will be required than simple gathering. Proposals will require triage, prioritization, clarification, etc.
  - The TF requested additional information on this process and workflow.
  - The TF confirmed that simple proposals, such as correcting a typo, will not require review by the MSAC or CSAC.
- The TF discussed the timeline of how the URC will phase out and the CSAC will phase in. It was suggested that there may need to be some overlap, and a request was made to officially confirm that 2019 will be the final ICD-10 update.
  - The TF requested additional clarification about the transition.

21.3. **Action Items**
- **WHO** – fix the typos in the text, bring feedback to Dr Boerma and inform TF about next steps after discussion with Dr Boerma.
- **WHO / TF** – prepare a background document on ICD-10 updates, both process and problems / considerations, that can inform how the CSAC should function, with guidance on timelines.

21.4. **Recommendations or Decisions**
- The TF recommends that WHO remain open to updating the needs of ICD-10 users and the decisions related to ICD-11 development.
- The TF recommends further clarity on how the transition from URC and RSG to CSAC and MSAC will be managed.
- The TF recommends that WHO consider the updated proposal internally and then revisit the approach with the TF for further specification and to address additional questions about the process and groups.

22. **Use Cases**

22.1. **Background**
- A report back from the side session on Tuesday was presented to the TF, including the evolution of the use case document into a strategy and position paper, and clarity about the audience (e.g. policy makers rather than classification users).
- The presentation clarified the underlying principles that modern health information is an essential national and global asset, that ICD is a critical component of health information and health systems, and that ICD is essential to health improvement and to universal health coverage.

22.2. **Key Discussion**
- The TF recognized that there are a number of uses of ICD coded information that had not been invented yet when ICD-10 was published, and that ICD-11 must both address these uses and be prepared for new uses still to arise. One such example is the future use of ICD coded information as a basis for predictions.
22.3. Action Items
- WHO – Update and reformat the document as outlined in the side session – a strategic placement document focusing on policy development in support of ICD implementation
- WHO – Update with the process for development of the conference documents and the feedback on this
- WHO – Update the workflow image to recognise that mortality is not just hospital data in much of the world
- WHO – Consider how quality data can be included in the data collection for financing as a use case.
- James Harrison – Circulate the data on predictive value of coding to WHO to inform the redrafting.
- TF – Provide any additional feedback to WHO
- WHO – Provide the next draft of the use case (a.k.a. strategy and position) document by July 2016.

22.4. Recommendations or Decisions
- The TF recommends that the description of the use cases in the document become more detailed and concrete.

Thursday, 13 April 2016 – 11:12

23. Post-2016 Plans

23.1. Background
- It was agreed that the October release will neither be titled a “release candidate”, nor will it include the words “test” or “testing”. This version will still go through the post-October evaluation process as outlined.
- Following the Revision Conference, the topic of national modifications will be revisited with a goal to have more clarity and a better defined process.

23.2. Key Discussion
- It was suggested that it might be useful to include a side session during the Revision Conference on national modifications to elicit feedback from countries that may want one, though other opinions suggested that this might emphasize the idea too much.
- The TF confirmed that the statistical reporting implications will be important to know before the Revision Conference.
  - WHO confirmed that a working meeting on the statistical implications/wishes for ICD-11 is planned for 7-9 June 2016 in Geneva.
- The TF suggested that recoding efforts for electronic mortality coding (e.g. with IRIS) will only be useful once ICD-11 is more stable. Right now mortality recoding should start with manual coding tests. Typical timelines for updating decision tables suggest this work will take at least 2 years, and it cannot be started until the ICD-11 MMS is stable.
  - This will include testing the new ways of coding, such as cluster coding and the enhanced post coordination.
- The TF suggested that the essential requirements for ICD-11 use should be defined, as knowing them will make them easier to address.
- The TF acknowledges that there will be a “bump” when transitioning from ICD-10 to ICD-11, but expressed concern about how big of a “bump” countries may be able to handle.
- The TF confirmed that there are certain limitations to what can be accomplished in 2017 given the increased lag time required to update medical health systems, a requirement before testing implementation.
- The TF confirmed that usability of the classification should be tested not just with the tabular list, but also the Reference Guide (volume 2) rules for cluster coding, etc., and that this work should be done in 2017.

23.3. Action Items
- WHO – Complete a review of the recommendations from the Revision Review to see if we are on track and have made the changes requested.
- WHO – develop a name for the October Release
- TF / WHO – request that each Member State that has a national modification do a review of whether or not ICD-11 (including postcoordinated) addresses their needs, and if not, where/how not. Develop the list of questions we need to have answered in this review so we are clear when we ask them to review and report back to us.
- WHO – Organize the statistical review meeting with relevant stakeholders in June 2016.
- TF – Contribute to the development of a document which outlines the requirements (essential uses) of ICD that ICD-11 will need to address.
23.4. Recommendations or Decisions

- The TF recommends that national modifications are routinely submitted to WHO before national implementation. However, there must also be a “direct entry” option to accommodate for national requirements.
- The TF recommends that the text in the Reference Guide (Volume 2) around this topic be edited accordingly.

Thursday, 13 April 2016 – 11:51

24. Revision Conference Agenda

24.1. Background

- An overview of timetable and updates discussed this week was presented.
- WHO shared that additional side sessions may be added to the agenda, space permitting.

24.2. Key Discussion

- The TF asked about process for further refining the schedule and participants for the Revision Conference.
  - WHO confirmed that the agenda is fairly stable, but that the TF is welcome to propose speakers for the topics.
- The TF asked about the process of invitations.
  - WHO confirmed that the expectation is that the invitations will be sent by the end of May.
- The TF asked if there would be simultaneous translation into multiple languages, which there will not be.
- The TF confirmed that all WHO Member States will be invited, but that 100% attendance cannot be expected.

24.3. Action Items

- WHO – Update the draft Revision Conference agenda and share with the TF and other groups.
- TF – Consider proposed speakers for the sessions and provide these suggestions to WHO.