### List of Participants:

<table>
<thead>
<tr>
<th>WHO Participants:</th>
<th>External Participants:</th>
<th>Observers:</th>
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<tr>
<td>☒  Lindy Best</td>
<td>☒  James Harrison</td>
<td>☒  Solvejg Bang (apologies)</td>
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<tr>
<td>☐  Can Celik (apologies)</td>
<td>☐  Stefanie Weber (apologies)</td>
<td>☐  Justine Boland (Thurs)</td>
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<td>☒  Robert Jakob</td>
<td>☐  Christopher G. Chute (apologies)</td>
<td>☐  Robert Chalmers (apologies)</td>
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<td>☐  Nenad Kostanjsek (apologies)</td>
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<td>☐  Lori Moskal (apologies)</td>
<td>☐  Lars Berg (apologies)</td>
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<td>☒  Molly Meri Robinson Nicol</td>
<td>☐  Vincenzo Della Mea (apologies)</td>
<td>☒  Richard Madden</td>
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<td>☒  Anneke Schmider</td>
<td>☒  Vera Dimitropoulos</td>
<td>☒  Lauren Moran</td>
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<td>☐  Hernan Velasquez (apologies)</td>
<td>☒  Anne Elsworthy</td>
<td>☐  Sam Notzon (apologies)</td>
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<td>☐  Stephane Espinosa (apologies)</td>
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<td>☒  Megan Cumerlato</td>
<td>☒  Kaori Nakayama</td>
<td>☒  Yukiko Yokobori</td>
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<td>☒  Julie Rust</td>
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<td>☒  Kees Van Boven (apologies)</td>
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<td>☒  Martti Virtanen (Wed – Thurs)</td>
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<td>☐  Ulrich Vogel (apologies)</td>
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<td>☐  Patricia Wood (apologies)</td>
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1. Welcome

1.1. Background

- The JTF Co-Chair welcomed participants and observers to the meeting. Given the presence of new observers for this meeting, introductions were made.

2. ICD Revision Conference

2.1. Background

- WHO gave a presentation on the ICD-11 Revision Conference which was followed by discussion.
- WHO provided the historical context surrounding ICD development, including the evolution in knowledge, purpose, and myriad uses of the classification. There was a focus on the primarily notable advances or features of each iteration.
- In light of the assumption that ICD-11 will be in use for the next 50 years, there are important questions related to the significant new features and notable advances for ICD-11, particularly the broader range of health information needs and the enhanced breadth and depth of the content.
- Key messages for the ICD-11 Revision Conference should focus on those things that set ICD-11 apart and represent the greatest improvements over ICD-10, as well as how ICD-11 will serve the future data needs.
- WHO also presented the most current model of ICD-11, including all components of the classification to date.

2.2. Key Discussion

- The discussion raised the concept of what the JTF and WHO imagine ICD-11 might have evolved to become, if we were able to look back from the perspective of 15 or 30 years from now.
- JTF members recognized that ICD is a long running project that has been ongoing for more than a century, and the needs and perspectives have changed and will continue to change into the future. They confirmed that it is important to consider how ICD-11 will work far in the future, but also to focus on what ICD-11 can and will do for users now.
- JTF members agreed that the diagram above is accurate in representing the multiplicity of purpose, though re-confirmed that the mandate of this group is to focus on the development of the entry point – the ICD-11 MMS.
At the same time, it will be important to ensure that no decisions taken in the context of the MMS compromise the needs of the other components. WHO is responsible for this integration perspective.

WHO confirmed that it was possible that the JTF may make decisions that, in retrospect, could have been made differently. However, the JTF is responsible only for giving the best possible advice to WHO with the information available at the time, allowing WHO to make the best possible decisions. Furthermore, there is little concern that the JTF members will make decisions that are “nonsensical”, given the expertise and experience present in developing and using classifications.

JTF members recognize that there may be items which need to be revisited when new information comes to light, and preparations should be made for dealing with the changing environment as such issues may arise.

- JTF members agreed that the MMS is the core; the primary vehicle through which other purpose-built ICD-11 classifications should link.
- After discussion about efforts of various stakeholders and involved experts to “apply ICD-10 to the development of ICD-11”, or to “corral ICD-11 into functioning the way that ICD-10 did”, the JTF members transitioned to discussing how ICD-11 will move beyond ICD-10 into the future, and what the future statistical needs will be. This was placed in the context of the discussion held at the statistical review meeting in Geneva from 7-9 June 2016.
- JTF members raised the point that, while the WHO perspective and needs are very important, the members of this group also stress the critical importance of other use cases and national requirements for implementation and use.
- JTF members understood that there will be two very important key audiences in the ICD-11 Revision Conference and it will be important to shift the focus of this group to address the perspective of Member States rather than individual interests of single users, TAGs, and WHO-FIC Network representatives. This will mean focus on the higher level issues related to the Sustainable Development Goals (SDGs), implementation, and health financing, rather than the specific clinical details and codes.
- A JTF observer raised the concept of using ICD-11 in allied health professions, as this is not fully represented in the information about ICD available at this time.
- WHO confirmed that there is internal work ongoing with a WHO communication expert to prepare the messaging for the ICD-11 Revision Conference to achieve a message that is, to the extent possible, appealing to the wide variety of stakeholders.
- During a review of the DRAFT ICD-11 Revision Conference Agenda, JTF members were reminded that the JTF will have 5 sessions during the WHO-FIC Network Annual Meeting to focus on the detail and continue the regular business of the group; one evening session, three closed day sessions, and one day session open to all members of the WHO-FIC Network.

2.3. Recommended Action Items

- WHO to update the Revision Conference Agenda and strategy based on the discussion today in preparation for planning the JTF Agenda for Tokyo

Monday, 11 July 2016 – 10:10

3. Briefing on the Statistical Review Meeting

3.1. Background

- The MMS Statistical Review meeting was held from 7-9 June 2016 in Geneva, Switzerland.
- A key topic of the meeting was on reporting progress towards the Sustainable Development Goals (SDGs) and the need for ICD-11 in that reporting, as well as the role of ICD-11 in public health surveillance.
- Another key topic related to prospectively predicting the future statistical needs across low, medium, and high resource settings, the increase in aging populations and how these deaths will be coded (and causes of death analyzed), the need for long-term improvement in data capture across settings, and the decreasing importance (in some situations) of a single, underlying cause.
- Meeting participants identified some key future needs, including
  - tabulation lists for the SDGs using ICD-11, ICD-10, or both
  - improved statistical guidance
  - a model for “block-level statistical reporting” for ICD-11
  - consideration to use cluster coding, or post-coordination for mortality
  - use of other data sources to address information gaps.
• The meeting participants also discussed a model for mortality data across Member States, which recognizes differences in resources and the stage of development of national health and health data collection systems:

- An important recommendation from the meeting was the need for an ICD-11 shortlist for use in countries newly implementing ICD.
- The meeting participants also reviewed more specifics on selected chapters, including the following:
  - Clarity around key structural decisions: Infectious diseases
  - Importance of blocks for reporting purposes – discussion on the ‘aesthetics’ of the browser
  - Views from epidemiologists/statisticians on the logic behind primary locations of certain infectious diseases and cerebrovascular diseases
  - Issues with secondarily located entities noted, including phantom blocks (those containing only secondarily parented entities)
  - External causes and discussion on ‘intent’
  - Significant decisions to be made around mortality use of post-coordination and clustering to enable simplification of structure
- Governance and the statistical use cases were also topics of discussion at the meeting, including:
  - Governance: WHO – develop Terms of Reference for the MSAC\(^1\) and CSAC\(^2\), while further defining the governance process.
  - Updating Cycle: Consider the recommendation that major updates in ICD-11 be limited to those needed for correction of major errors or appearance of new diseases
  - Transition: Resource issue (personnel), timing issue (overlap), functional issue – several recommendations made
  - Electronic tools: How to undertake large scale remodelling of tools such as Iris. Need to focus this work on future use cases and where possible use more advanced technology/techniques

**3.2. Key Discussion**

- JTF members appreciated the diagram modelling mortality data across WHO Member States, and the desire to have consistency in the data collected between different versions, whether a Primary Care (PC) version, a short-list for countries new to ICD, or the full ICD-11-MMS.
- JTF members recognized that there will be some lack of familiarity with ICD-11, and this is to be expected as it is not ICD-10. At the same time, JTF members confirmed that there are still some “classification rules” that should be respected in ICD-11.
- JTF members confirmed that it MUST be possible to roll-up the codes into the broader entities of the simplified tabulation versions in order to maintain consistency and comparable data.
- A key topic of discussion related to identifying what would be necessary to make the simplified tabulation work, and the response from JTF members was that the easiest way to ensure continuity would be to allow coding to the block level as the simplified version.
  - JTF members recognized that the majority of blocks may be relevant to this block-level coding, but that there may be other blocks which should be left out of the simplified tabulation list.
  - At the same time, JTF members also recognized that coding to the block level will require a review of the block level codes to ensure that they are useful for coding.
- WHO confirmed that there is no specific barrier to “constellation” or “block level coding” in the current structure.

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\(^1\) Medical and Scientific Advisory Committee
\(^2\) Classification and Statistics Advisory Committee
3.3. Recommended Action Items
- WHO – complete a review of chapter and block level codes with the potential consideration of allowing so-called “block level coding” as the short-list

3.4. Recommendations or Decisions
- The JTF concurred with the desirability of an ICD-11 short list for introducing implementation to Member States (MS), potentially by coding to the block level.

Monday, 11 July 2016 – 11:05

4. Chapter Review – Introduction to Chapter Reviews

4.1. Background
- In order to facilitate a more efficient technical review of chapters, WHO prepared a review of common issues, already known, that do not require addressing in the current round of review. These include:
  - **There are no “other” and “unspecified” residuals at every level of the hierarchy.** This is intentional, and may be due to enumeration of all possible options (e.g. cranial nerve injuries) so that an “other” category is nonsensical, or the inclusion of many very detailed levels where the inclusion of residuals would result in a “code explosion”. When reviewing residuals, identify places where residuals are unnecessary and should be suppressed, or where residuals are necessary but currently missing.
  - **Residuals are not and should not be in the foundation.** As residuals are classification-specific (linearization-specific), they are automatically generated and are reviewed only in the context of that classification (linearization).
  - **At present, the formatting is inconsistent.** For example, some inclusion terms are not capitalized, “visual clues” with the headings are sometimes difficult to follow, and not all entities have codes. Much of this formatting can and will be done algorithmically, saving a great deal of time. As such, spelling and formatting feedback is helpful and appreciated, but not absolutely necessary in this round of review and should not be the priority if it detracts from the other, more critical aspects.
  - **The code numbers continue to change on a daily basis.** While the classification is still changing the allocation of codes will change due to ongoing changes in the hierarchy. Feedback should be placed into the template provided by WHO for the review as much as possible. If feedback is done through another format type, the title (or URI) and NOT THE CODE should be used as the reference. Feedback received linked to a code number only will not able to be addressed by WHO. The final code set will allow for all entities in a given chapter to begin with the same character (0-9, A-R excluding O and I) for ease of recognition by future users.
  - **Some ICD-10 index terms are not included in ICD-11.** This may be intentional as TAG members did remove many of the items that they considered to be out of date or obsolete. Also, many terms were translated into “natural language” to be grammatically correct and to facilitate translation. The comparison of index terms between ICD-10 and ICD-11 has been done electronically, and WHO is in the process of reviewing all discrepancies and adding back items, as appropriate. Examples include the term “Acute, NOS”, which is incomplete, or “Cancer, tongue, posterior third”, which was updated to “Cancer of posterior third of tongue”.
  - **It is a principle that all exclusion notes in ICD-11 must link specifically to the concept being excluded, not just a term.** At present, not all linking has been completed, but work is ongoing. WHO confirms that all exclusion notes will explicitly link to other concepts within the MMS and will include the relevant code. This linking is done through the foundation using the URIs.
  - **The shoreline remains a concern.** While WHO and JTF members recognize that multiple codes may be used to fully describe the necessary detail for a given condition, it is still necessary to maintain a minimum level of precoordinated detail such that the concepts are meaningful, e.g. there is no suggestion to have a single code for cancer using post coordination to identify location and histopathology/morphology. In essence, just because something COULD be post-coordinated does not mean that it should or will be.
  - **Additionally when considering the shoreline, just because one relevant anatomical site is precoordinated does not mean that they should all be.** Concepts that are of statistical or public health importance, or that are particularly common, may remain precoordinated with other anatomical detail being captured with post-coordination. WHO recognizes that this is a judgement call, in some cases, and is grateful for particular feedback about precoordinated entities that might be necessary, not just possible.
  - **In general, WHO recommends using the coding tool to search for concepts rather than tabular browsing.** This will address the issue of items that are post-coordinated, are inclusions, or which might be primarily parented elsewhere.
4.2. Key Discussion

- JTF members expressed concern about the potential loss of index terms that some experts might consider “obsolete”. If a clinician in a given country is still using that term, even if doing so incorrectly, it will still be necessary for coders to be able to identify where that should be coded. WHO confirmed that if JTF members are aware of terms that are frequently used or documented in any given country that are missing from ICD-11, these should be submitted, either through the coding tool as demonstrated, or as a list.
- WHO provided a list of example exercises that JTF members completed using the coding tool to identify “how to code” the given concepts. Feedback from JTF members indicated that this was a very useful exercise, and that it was now much more clear as to how to use the coding tool and how post-coordination is implemented.

Monday, 11 July 2016 – 13:30

5. Chapter Review – Infectious Diseases

5.1. Background

- The meeting with statistical users yielded proposals for change to the following items:
  - Move prion diseases from Nervous system (Ch.9) to Infectious (Ch. 1)
  - Put all types of infectious meningitis and encephalitis in Ch. 1
  - Consideration potentially moving upper and lower respiratory infections to a Respiratory infections block in Ch. 1. Include infectious bronchitis
  - Ensure skin manifestations of infectious diseases are in Ch.1 and not in the Skin chapter.
    - All forms of leishmaniasis should be in Ch. 1. Currently, cutaneous and mucocutaneous leishmaniasis are primarily parented to the Skin chapter.

5.2. Key Discussion

- JTF members agreed that it would not be appropriate to include non-infectious conditions in the infectious diseases chapter. At the same time, it is desirable to keep conditions potentially due to multiple etiologies together for consistency, tabulation, and ease of navigation, and sometimes missing information about the aetiology.
- JTF members discussed prion diseases at length, noting that some may have congenital transmission, but even in these cases, it is possible that it may still be passed to other individuals. As such, this is a unique mechanism of transmission.
- It was recognized by JTF members that, at present, both meningitis and encephalitis are split between the infectious diseases chapter and the nervous system chapter, based on their etiology. JTF members thought that this was confusing and not ideal for navigation, consistent with the recommendations from the statistical review meeting.
- JTF members agreed that meningitis and encephalitis should be kept together. Since it is not advisable to include non-infectious conditions in the infectious diseases chapter, the groups will have to be in the Nervous System chapter, with multiple parenting of the infectious conditions into the infectious diseases chapter.
  - WHO advised that there are some infectious meningitis / encephalitis conditions that are of significant public health interest, that may be WHO notifiable conditions, and which might cause awkwardness if not included primarily in the infectious diseases chapter. As such, WHO is not certain that this recommendation can be accepted, and expects that the groups will have to remain split between the two chapters.
- Regarding respiratory infections, JTF members noted that the specific placement is not of critical importance for many of the conditions, clarifying that (clinically and in documentation), there is not typically a distinction made between infectious and non-infectious bronchitis.
- On the other hand, JTF members did note that many people do die of influenza, therefore the placement of this condition does have an impact on mortality statistics.
- JTF members suggested that, in the absence of compelling evidence mandating a change, legacy should trump with regard to the question of moving certain conditions to new chapters. One JTF member further clarified that legacy might be “taking the easy way out” of the decision, and might miss opportunities for advancement or more forward thinking in the MMS.
- JTF members confirmed that continuity over time is desirable. Where there is a rationale for change, the changes can be accommodated for, but there was a question about how to justify the effort required to make the changes in data reporting systems in the absence of compelling information indicating that the change makes things better or more accurate.
- Regarding skin manifestations of infectious diseases, JTF members confirmed the understanding that the Dermatology TAG does not strongly object to these conditions being primarily parented into the
Infectious Diseases chapter, provided that they are also multiply parented into the skin chapter so as to not disturb the dermatology specialty classification (linearization).

- JTF members agree that the majority of the skin manifestations of infectious diseases will be primarily parented into the infectious diseases chapter. The exception to this rule will be warts, as these are exclusive to the skin chapter.

### 5.3. Recommended Action Items

- **WHO** – include all prion diseases in the infectious diseases chapter in a single group.
- **WHO** – consider the JTF recommendation regarding grouping of meningitis and encephalitis, while making the decision most relevant for international reporting requirements.
- **WHO** – review the respiratory infections in light of guidance from the JTF and finalize code placement in line with the recommendations.
- **WHO** – primarily parent all but one of the skin manifestations of infectious diseases to the infectious diseases chapter while leaving the multiple parenting to the skin chapter intact.
- **WHO** – primarily parent warts into the skin chapter, with multiple parenting to the infectious diseases chapter. This is the only exception to be primarily parented to the skin chapter.

### 5.4. Recommendations or Decisions

- JTF members recommend that Prion diseases should remain grouped together with primary parenting in the infectious diseases chapter. Secondary parenting into the Nervous System chapter is desirable.
- JTF members recommend that all meningitis conditions be grouped together, likewise all encephalitis conditions be grouped together, and that these two groups be primarily parented into the nervous system chapter. JTF members acknowledge that this might be a recommendation that WHO will not accept.
- JTF members recommend using legacy to determine placement of the respiratory infections except where compelling evidence justifies a change.
- JTF members recommend to primarily parent skin manifestations of infectious diseases in the infectious diseases chapter. The exception to this rule will be warts, as these are exclusive to the skin chapter.

### Monday, 11 July 2016 – 14:00

### 6. Chapter Review - Neoplasms

#### 6.1. Background

Neoplasms of brain and central nervous system have been combined in one grouping based on the clinical rationale that behaviour (benign or malignant) does not necessarily affect treatment or outcome.

- **Option 1** – keep new view of neoplasms of the brain
- **Option 2** – separate benign and malignant neoplasms as they were in ICD-10

#### 6.2. Key Discussion

- JTF members suggested that the titles of the three main axes are now incorrect, as the group “malignant neoplasms” does not include the malignant neoplasms of the central nervous system. Likewise, the group titled “benign neoplasms” has the same issue.
- JTF members do acknowledge the clinical utility with regard to interventions inherent in this classification, as even benign brain tumours can be quick and lethal. However, JTF members were concerned about how this change would affect the continuity of statistics.
- JTF members also noted with concern the use of “out of date” terminology as it relates to brain tumours and suggested that the new terminology be incorporated, e.g. “primary neoplasm of the brain”. WHO confirmed that this can be done fairly easily, but noted that there would be some potential complications as related to neoplasms of the cranial nerves.

#### 6.3. Recommended Action Items

- **WHO** – include the current terminology as it relates to brain tumours as index terms in the neoplasms chapter. This will include changing “malignant” and “benign” neoplasms of the brain and central nervous system to “primary” and “secondary” neoplasms of the brain and central nervous system.
- **WHO** – retain the current first level split of “malignant” versus “benign” versus “neoplasms of the brain and central nervous system”.

#### 6.4. Recommendations or Decisions

- JTF members recommended the use of “primary neoplasm of the brain” as more current terminology and avoid the terms benign or malignant as they are less applicable in this context.
- JTF members noted the concern about discontinuity in data, but did not recommend changing the new primary axis of the neoplasms chapter.

### Monday, 11 July 2016 – 14:20
7. Chapter Review – External Causes

7.1. Background

- Feedback was received from WHO staff from other technical units as well as from the Statistical Review meeting that identified some perceived issues with the sections on transport events in the external causes chapter, primarily focusing around the concern that ICD-11 is “more difficult to use” than ICD-10 was, while recognizing that even ICD-10 did not code traffic accidents (a.k.a. Unintentional road injury) well, as the most relevant detail was in “too deep”.

- WHO confirmed that, in ICD-11, the detail distinguishing “traffic” versus “non-traffic” incidents has been brought up one level while strong back-compatibility with ICD-10 has been verified at the four-character level, though comments received suggested that this was still “too deep” and that there was too much detail and depth, in general, in this area. It was suggested that ICD-9, with the primary split of “traffic vs non-traffic vs other” did a better job of allowing collection of the relevant detail.

- WHO and the relevant TAG have suggested that the revised block on transport has made changes specifically to resolve the problems that were identified with ICD-10, and notes that the split has been made to enable identification of important and emerging types that cannot be identified in ICD–10.

- At the same time, the TAG has refined and revised terms and definitions to clarify and to fill gaps identified in ICD-10.

- WHO confirms that the structure has been reordered as follows:
  - ICD-10: mode, counterpart, user role and traffic status
  - ICD-11: mode, traffic status, user role, counterpart.

7.2. Key Discussion

- JTF members suggested that more post-coordination should be used here to help address the currently represented “code explosion”. They also note that, even in high resource settings, the level of detail outlined in the precoordinated hierarchy is often unavailable. JTF members recognized that the system of data collection in Australia, for example, does give the “four component” outlined above and that it is therefore desirable to collect and use the information this way. However, JTF members confirmed that this is not done in all Member States, either consistently or at all, and they therefore cannot implement the full level of precoordinated detail as in the current draft.

- JTF members suggested that using post-coordination of the different aspects would allow for the documentation and collection of as much information as possible, even if the existing “decision tree” inherent in the structure cannot be explicitly followed (e.g. if one knows counterpart but not user role, this information could not be collected in the current model).

  - The co-chair explained that full pre-coordination had been retained in the transport module for ICD-11 due to the fact that prior to very recently, post-coordination could not be implemented. The transport module had been designed in a way that would allow a degree of post-coordination. There is no objection to increasing the use of post-coordination now that it can be done, noting in particular the ‘counterpart’ concept.

- JTF members raised the concept that there will be no defaulting to “traffic” as was done in ICD-10, as this default is no longer necessary.

- JTF members discussed moving “intent” to a lower level, but did not accept the idea as some groups, such as Ministries of Health and those groups concerned with violence or suicide have indicated that it would not work for them.

  - The JTF members did agree to remove the section called “intent pending” and to replace the concept with an extension code addressing the same concept.

  - At the same time, JTF members rejected the idea of post-coordinating all of intent, as this would allow for a significant decrease in the total number of codes, but might also risk losing the information on intent, which is not desirable.

- JTF members agreed that a way should be provided to allow distinction of suicidal from non-suicidal intentional self-harm; that this be addressed through the creation of extension codes to address the issue.

7.3. Recommended Action Items

- WHO – simplify the content of the chapter through decreasing the number and depth of codes by moving some of the granularity into the post-coordination space.

- WHO - remove the section grouped as “intent pending” and create an extension code (administrative, pre-fix qualifier) that would address the concept.
WHO - create extension codes to address suicidal vs non-suicidal intentional self-harm

7.4. Recommendations or Decisions

- JTF members recommend maintaining the structure of the chapter as currently represented in ICD-11 while seeking to simplify the content through decreasing the number and depth of codes by moving some of the granularity into the post-coordination space.
- JTF members recommend removing the section grouped as “intent pending” and creating an extension code that would address the concept.
- JTF members recommend the creation of extension codes to address for suicidal vs non-suicidal intentional self-harm.

Monday, 11 July 2016 – 14:40

8. Chapter Review – Nervous System

8.1. Background

- WHO provided some background on Cerebrovascular diseases, namely:
  - Cerebrovascular diseases (CVD) are the 2nd leading cause of death and disability worldwide.
    Since 1970, the incidence of stroke has more than doubled in low and middle-income countries.
    - Cerebrovascular diseases were distributed over multiple chapters in ICD-10.
    - Nervous system had codes for transient cerebral ischaemic attacks and vascular syndromes of brain.
    - Circulatory system had codes for intracranial haemorrhage and ischaemic events.
    - Symptoms, signs and abnormal findings had the code for Abnormal findings on diagnostic imaging of CNS-clinically ‘silent cerebral infarction’
      - 90% of vascular diseases present as ‘silent’ diseases, affecting mental capabilities.
    - Vascular dementia was included in Chapter 5 Mental and behavioural disorders in ICD-10.
  - Improved neuroimaging techniques has been the catalyst for rapid and important scientific progress in the area of cerebrovascular diseases.
  - Close links between acute stroke symptoms, CVD causing insidious cognitive impairment and dementia, and ‘silent’ CVD mean they should be classified together.
  - Whereas cerebrovascular diseases by definition implies the involvement of brain vessels, all the symptoms and short and long term effects are mediated by symptoms from the brain itself.
  - In the general population cerebrovascular diseases are (correctly) perceived as diseases affecting the brain, neurologists often manage them, and the focus in campaigns on prevention and treatment of acute stroke are on early recognition of brain symptoms.

- Option 1 - Nervous system
  - Revisions made in ICD-11 address several coding limitations in ICD-10.
    - Diagnostic criteria for transient ischaemic attack.
    - Distinction between ‘silent’ infarcts and cerebral ischemic stroke.
    - The coding of sequelae of cerebrovascular disease.
  - Revisions made preserve the compatibility of the classification with a large body of past and ongoing research, and improve the clarity and clinical utility of the classification.

- Option 2 – Circulatory system
  - Moving the classification of CVDs out of the circulatory system will have significant impact on data continuity.

- Where should CVDs be classified in ICD-11?
- Of note, WHO shared that the Neurology TAG and Circulatory Work Group (WG) of the Internal Medicine TAG had previously agreed that all CVD conditions should be grouped together, and that the primary parent would be the nervous system chapter.

8.2. Key Discussion

- JTF members recognized CVD has historically been split across multiple chapters, but reiterate the desire expressed during the discussion on infectious diseases to keep conditions grouped together for tabulation and navigation purposes.
- JTF members acknowledged the agreement by the TAG and WG experts to primarily parent the CVD conditions to the nervous system chapter, but commented that it was odd to see vascular diseases in the nervous system chapter. They suggested that, although the sequelae may largely be related to the nervous system, the acute phase and etiology of the conditions is clearly vascular.
- The option of splitting the conditions based on treatment or sequelae was suggested but rejected by JTF members as though it might work for morbidity, such a split would not work well for mortality.
JTF members suggested that there were pros and cons to inclusion in each chapter, but also raised the recurrent theme that, in the absence of compelling evidence, legacy would trump. JTF members noted that consensus was very desirable, but did not see evidence for making the change beyond consensus.

JTF members did agree strongly that all cerebrovascular diseases should be grouped together with the exclusion of vascular dementia, which should remain in neurology chapter.

JTF members noted that in other cases, entities are parented into the chapter of origin or etiology, namely where they arise rather than to the system that they may target or where sequelae are parented. As such, they recommended primary parenting in the circulatory system chapter.

8.3. Recommended Action Items
- **WHO** – primarily parent all Cerebrovascular diseases (excluding vascular dementia) in one group within the circulatory system chapter, with secondary parenting to the nervous system chapter.

8.4. Recommendations or Decisions
- JTF members recommend that there should be no change to the existing structure of cerebrovascular diseases, but that the parenting of the group should be changed.
- JTF recommends that all Cerebrovascular diseases (excluding vascular dementia) be grouped together and that they be primarily parented to the circulatory system chapter.

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Monday, 11 July 2016 – 15:00

9. Chapter Review – Blood and Blood Forming Organs

9.1. Background
- WHO confirmed that the minor issues identified in the feedback received to date have already been corrected, including:
  - The excludes notes at beginning of chapter have been reviewed (which triggered a review of the other chapters, as well)
  - Highlighted issues with definitions have been corrected
  - Shorelining and typos have been fixed
  - A duplicate concept found by reviewer has been addressed
- Major issues identified in feedback for discussion
  - Many rare diseases identified that has led to a very detailed chapter. The suggestion is that the shoreline should be redone.
  - Is there criteria that can be used to determine which rare diseases warrant a code in the MMS?
  - More clinical review suggested but already two different TAGs have participated and agreed on content. Field trials may help with this concern.

9.2. Key Discussion
- JTF members noted that the chapter currently contains a huge number of rare diseases, and that this makes the chapter a bit too detailed and complex. A review and redrafting of the shoreline was suggested. At the same time, it will be important to identify criteria for which rare diseases will have an independent code in the MMS and which will be inclusion terms.
- JTF members recognized the extraordinary work and many meetings involved between the Rare Diseases TAG and the Haematology Working Group to develop the current compromise position. It is acknowledged that any changes recommended by this group may result in additional feedback from or to the TAG and WG.
- JTF members noted that field trials may help to identify some solutions within this chapter, but cannot be relied upon to provide a systematic review.
- Importantly, JTF members agreed that conditions should not be “out” of the MMS just because they are rare, as some of them are quite important. The difficulty is the criteria for what makes one condition “important” while some other is not.
- JTF members suggested an interim solution that if the conditions fall at the 6 character level or higher, they should be maintained. Those conditions at lower levels of coding depth will be clicked out of the MMS, consistent with the requirement that the code digit length not exceed 7 digits, including a potential cluster code. JTF members agreed that arguments could be made for moving some of the conditions back in, but that efforts could not be made at this time to restructure the chapter to accommodate.
- JTF members noted that individuals or organizations interested in coding each disease independently could use the URIs as reliable codes.

9.3. Recommended Action Items
- **WHO** – organize a systematic review of the shoreline of this chapter.
- **WHO** – click out of the MMS all rare conditions which fall below 6 levels of hierarchy depth.
9.4. Recommendations or Decisions

- JTF suggested a review of the shoreline to decrease the level of detail and number of very rare diseases included in the MMS version of the chapter.
- JTF suggested an interim solution that if the conditions fall at the 6 character level or higher, they should be maintained. Those conditions at lower levels of coding depth will be clicked out of the MMS.
- JTF suggested use of URIs or a specialty classification (linearization) for stakeholders specifically interested in the less-common conditions.

Monday, 11 July 2016 – 15:30
10. Chapter Review - Immune

10.1. Background

- Minor issues in feedback
  - Number of issues raised are being referred back to the TAG
- Major issues in feedback
  - Feedback indicated the chapter is too detailed
  - Should the entity *hypersensitivity pneumonitis* be included in the respiratory chapter?
  - Reviewed by two people – one said yes, the other said no
  - Should primary parents for all systemic immune diseases (following the taxonomy rules) be in the immune chapter?

10.2. Key Discussion

- JTF members noted that a number of issues in this chapter have been referred back to the TAG for further clarification.
- JTF members reviewed the responses to the question on the appropriate location for hypersensitivity pneumonitis and acknowledged that the two opinions contradicted each other.
- Recalling the decision to move cerebrovascular diseases to the circulatory system chapter given the vascular etiology, the JTF members recommended placement of this condition in the immune system chapter as the etiology is “hypersensitivity” in this case.
- JTF members further acknowledged the potential difference between local reactions in a given body system and systemic reactions in the immune system chapter.

10.3. Recommended Action Items

- WHO – primarily parent *Hypersensitivity pneumonitis* into the immune system chapter.

10.4. Recommendations or Decisions

- JTF recommended placement of this condition in the immune system chapter

Monday, 11 July 2016 – 15:50
11. Chapter Review - Ear

11.1. Background

- Minor issues identified in feedback corrected
  - Shorelining and typos fixed
  - 7 character codes removed
  - Inclusion overlaps corrected

11.2. Key Discussion

- JTF members raised no additional concerns or inquiries about this chapter.

Monday, 11 July 2016 – 15:55 & Tuesday, 12 July 2016 – 9:00
12. Chapter Review - Injuries

12.1. Background

- Minor issues identified in feedback corrected
  - Shorelining and typos fixed
  - Missing residuals identified and fixed
  - Concept of ‘Shaken baby syndrome’ has been removed. It can be captured by codes for the three components of the syndrome (i.e. subdural haematoma, cerebral oedema and retinal haemorrhage)
  - Recommendation to remove section on Maltreatment from this chapter as it is a duplicate concept with external cause codes
- Major issues identified in feedback for discussion
  - Level of specificity for injuries (e.g. fracture types).
    - Is it specific enough now that post-coordination options are available and visible?
  - Should these entities be precoordinated?
  - Definitions required for minor and major lacerations of blood vessels and internal organs
- Are the words sprain and strain synonymous?
  o Titles with sprain but definition is strain, should inclusion for strain be ticked in to appear in Tabular?
  o Also there are a mix of strain and sprain in the titles. Should these be made consistent
- The Neurology TAG has included detail that relates to the mass effect, region and midline shift for epidural and subdural haemorrhages. This detail may not be available at global level and leads to an increased coding depth. Currently, this detail is only in the foundation.
  o Option 1 - retain this level of detail in precoordinated entities in the MMS
  o Option 2 - post-coordinate this level of detail

12.2. Key Discussion
- JTF members noted that extensive work had been done on the list of fractures both before the Cologne meeting in April 2016 and after in response to comments received. It was suggested that the current version is sufficient for the Tokyo Release.
- JTF members accepted that additional work will be done on the definitions of minor and major lacerations of blood vessels and internal organs, recommending that additional qualified references for the definitions should be sought and referring the development of the content back to the Injuries and External Causes (IEC) TAG. At the same times, some of these conditions can and should be moved into the post-coordination space.
- JTF members confirmed that the terms “sprain” and “strain” should both appear in the titles.
- Regarding the question about haemorrhage, and the currently precoordinated concepts of mass effect and midline shift, space-occupying lesion, etc. associated with haemorrhage, the JTF recommends that these be moved into the post-coordination space following verification that post-coordination will cover these concepts so they are not lost.
- JTF members also agreed that the detail related to mass effect of epidural and subdural haemorrhages should be post-coordinated, with the caveat of ensuring that the conditions can be represented by post-coordination using codes already present in ICD-11-MMS.

12.3. Recommended Action Items
- WHO – ensure titles are consistent with the terminology of “sprain or strain” across the MMS (and foundation).
- IEC TAG – review and redraft any definitions related to minor and major lacerations of blood vessels and internal organs
- WHO – review the post-coordination of mass effect and ensure the ability to post-coordinate the concepts before removing them from the MMS.
- ??? – develop sanctioning rules around the newly post-coordinated concepts. It is unclear who is responsible for this task.

12.4. Recommendations or Decisions
- JTF accepted the suggestion that the current level of precoordination as related to injuries, particularly fracture types, has been reviewed and no additional changes are recommended at this time.
- JTF recommended review and redrafting of the definitions / descriptions of minor and major lacerations of blood vessels and internal organs and that some be moved into post-coordination to simplify the list.
- JTF recommended correcting all titles to have “sprain or strain” included.

Monday, 11 July 2016 – 16:15

13. Chapter Review – Circulatory System

13.1. Background
- Minor issues identified in feedback corrected
  - Highlighted issues with definitions corrected
  - Shorelining and typos fixed – unnecessary 6 character codes fixed
  - Duplicate concept found by reviewer corrected
  - Suggested additional exclusions added
  - Missing necessary residuals added
- Major issues identified in feedback for discussion
  - Chronic rheumatic heart diseases have now been interspersed with the non-rheumatic heart diseases, with the heart valve (mitral, aortal, tricuspid, pulmonary) now providing the axis within ICD-11.
  - Acute rheumatic fever has been moved to Infectious diseases. The move of Rheumatic fever without heart involvement was initially requested by the Internal Medicine TAG
Cardiomyopathy has splits on types and then further split on familial and nonfamilial. Question asked “is nonfamilial the same as the primary type?” Suggested to remove codes for nonfamilial, make it an inclusion? Familial has been added to the extension codes for possible post-coordination. Does TF agree?

- CB43 Cardiomyopathy
  - CB43.1 Dilated cardiomyopathy
  - CB43.2 Hypertrophic cardiomyopathy
    - CB43.21 Non-obstructive hypertrophic cardiomyopathy
    - CB43.22 Obstructive hypertrophic cardiomyopathy
    - CB43.2Y Other specified hypertrophic cardiomyopathy
    - CB43.2Z Hypertrophic cardiomyopathy, unspecified
  - CB43.3 Endomyocardial cardiomyopathy
    - CB43.31 Endomyocardial eosinophilic disease
    - CB43.32 Endomyocardial cardiomyopathy, unspecified
  - CB43.4 Endocardial fibroelastosis
  - CB43.5 Alcoholic cardiomyopathy

### 13.2. Key Discussion
- JTF members recognized the changes in the chapter which now classifies chronic rheumatic heart diseases first by valve and then later by whether or not they are rheumatic. Furthermore, they note that the acute rheumatic heart diseases are in the infectious diseases chapter as advised by the Internal Medicine (IM) TAG.
  - The JTF recognized that, in areas where antibiotics are relatively available, the rheumatic nature of the condition is less of a concern, but that this is not the case for everyone. This being said, the current structure was still accepted.
- JTF members reviewed the updated organization of cardiomyopathy, noting that they are now split on type, then a further split of familial versus non-familial. JTF members questioned whether “non-familial” and “primary type” refer to the same condition in this case.
- JTF members recommended that non-familial conditions should be identified as inclusion terms and not included in the MMS, while familial conditions could be identified using the existing post-coordination extensions.
  - Upon review, it was noted that this change flattens and simplifies the structure in a desirable way.
- JTF members heeded the comments that there may be many additional issues of importance in this chapter, and that there is not sufficient time before Tokyo to address them all. Ideas of how to prioritize the issues were discussed.
- JTF members also noted that the preferred term for acute and subacute endocarditis is infectious endocarditis

### 13.3. Recommended Action Items
- WHO – remove non-familial cardiomyopathy from the MMS and ensure it is included in the correct location as an inclusion term.
- WHO – remove familial cardiomyopathy from the MMS and ensure it is included in the correct location as an inclusion term. Create a sanctioning rule that allows use of “hereditary” with “cardiomyopathy” and it subordinate conditions to tie to the existing foundation entity.

### 13.4. Recommendations or Decisions
- JTF recommends maintaining the current structure, organized at the first level by valve.

### 14. Chapter Review – Endocrine, Nutritional and Metabolic
#### 14.1. Background
- There were not many major issues raised in the feedback. The minor issues identified are being reviewed and incorporated.
- Advice had been requested on multiple polyglandular tumours and endocrine tumours, which are not common conditions. At present, these are subdivided by activity, though they are typically benign and clinicians may not classify these conditions in this way. The question was whether or not these should move to the Neoplasms chapter and/or how they should be classified. There may also be a need to cut
down the level of granularity in this section, with a recommendation to code the actual tumour using the Neoplasms chapter and code the endocrine activity here.

- The options are:
  - Code the specific type of Neoplasms from chapter 2 (if the specific type of neoplasms is known) while coding also multiple endocrine neoplasms (activity) from chapter 6.

14.2. Key Discussion

- A JTF member raised the concern about how this should be coded if the specific neoplasm is not known, or if it is of uncertain behaviour. WHO confirmed that if the behaviour is uncertain, this can be coded from chapter 2. WHO suggested that it would not happen that the specific neoplasm is not known, as coding multiple endocrine neoplasms is insufficient information and by the time this diagnosis is reached, extensive testing should have been done.
- JTF members questioned the impact of these conditions on national and international health statistics, particularly given the relative rarity of the diagnoses.
- A JTF member raised the issue of reimbursement, suggesting that treatment for this condition might not be reimbursed if the code was “not a neoplasms code”. JTF members agreed that this was worth considering, even if not a deciding factor.
- JTF members agreed that the primary concern for this section relates to the correct placement in the classification rather than the level of detail.
- Another JTF member raised the concept of the Neuroendocrine tumours (NET), as there are some similarities between NET and multiple endocrine neoplasms (MEN). However, Neuroendocrine tumours is in the Neoplasms Chapter, and multiple endocrine neoplasms are in the Endocrine chapter with the requirement that one cluster code with the Neoplasms chapter.

14.3. Recommended Action Items

- WHO – move multiple endocrine neoplasms, not otherwise specified and Neuroendocrine tumours, not otherwise specified to malignant neoplasms, unspecified. The other entities will remain in the endocrine chapter.

Tuesday, 12 July 2016 – 9:37

15. Chapter Review – Genitourinary

15.1. Background

- Several major issues were raised in the cover sheet on which WHO would like advice. The first issue was related to adhesions. The question was whether or not these should be moved into the clinical manifestations chapter to be applied consistently to all applicable body systems.
- The second issue related to glomerular disease. The level of granularity in ICD-11 is reduced as compared to ICD-10, and the JTF is asked to advise whether the current list is sufficient to collect necessary information. The review completed from a mortality perspective was satisfied with the simplification.

15.2. Key Discussion

- JTF members noted that adhesions are not an issue relevant for mortality, but it is relevant for morbidity.
- JTF members also noted that, though pelvic adhesions are a specific issue of importance to the GU specialty, this is not the only place where adhesions can occur, and there is a desire to classify similar conditions consistently.
- JTF members recognized that there is a logic to treating adhesions consistently as a clinical manifestations, but this was accompanied by the caveat recognizing that there may be specifically occurring adhesions, such as pelvic adhesions, for which there may be value in retaining these precoordinated codes.
- Regarding glomerular diseases, JTF members suggested that the shorter list is sufficient, particularly when combined with the extension codes in the axis of morphology/histopathology. At the same time, there were some questions about how this will work and if the values necessary are, indeed, already included in the histopathology axis.
- A JTF member raised a question about dropping ICD-10 3-character level codes, as well as the decreased number of 4-character entities. There was a suggestion to seek additional input from the morbidity perspective.
- JTF members feel that the level of detail is sufficient, but suggested that there may be value in including a few more precoordinated codes. However, there was no advice about which additional detail / codes should be included.
- JTF members noted that, under the glomerular diseases, there exists a group called “Glomerular disease classified by clinical features or syndromes”, which is the only child in that group, and seems to be a superfluous level of detail. JTF members recommended dropping the “extra” hierarchy layer.
15.3. **Recommended Action Items**

- **WHO** – seek additional advice on pelvic adhesions from GU experts
- **WHO** – review the histopathology axis to ensure the necessary values are present to cluster with glomerular disorders
- **WHO** – “click out” the entity “Glomerular disease classified by clinical features or syndromes” from the MMS, but leave it in the foundation.

15.4. **Recommendations or Decisions**

- JTF recommended a general rule that there should not be “extra levels of hierarchy”, defined as groups with only one child that has children underneath. When this occurs, the “intermediate” level, should be clicked out of the MMS.

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**Tuesday, 12 July 2016 – 9:58 and Thursday, 14 July at 9:02**

**16. Chapter Review - Musculoskeletal**

16.1. **Background**

- WHO reported a recommendation that emerged from the Statistical Review meeting to delete the grouping for *Low bone mass disorders* and move the subordinate codes up one level.
- It was also reported that work continues on the musculoskeletal system chapter based on the feedback received from the working group in Köln in April. The JTF feedback was received a bit later than planned (7 July 2016), and will therefore be reviewed during and after this meeting.
- WHO reported that a primary concern for this chapter is the high number of eponymous entities. Another is that there are many “extra” levels of hierarchy.
- The musculoskeletal system chapter was later taken into a working session for review by a small group of JTF members and observers in a break-out session at the same time as the digestive system chapter.

16.2. **Key Discussion**

- JTF members acknowledge that the existing entity “low bone mass disorders” is a level that may look extraneous, and a suggestion was made to remove this level from the MMS, allowing the children to move up one level.
- Another JTF member suggested that an alternate option would be to delete the level above, *Osteoporosis and metabolic bone disease*, keeping *low bone mass disorders*.
- In the breakout session, additional feedback was provided.
- The breakout group was able to complete the review of the entire chapter. Preliminary comments indicate that the current chapter is significantly more refined than the version that was reviewed last year.
- The issues identified during the review were significantly less major, such as identifying unnecessary levels of hierarchy.
- Some minor issues included
  - Suggestions to move some concepts, such as “neck pain” to the clinical manifestations chapter
  - Adding “osteitis” as a separate entity to “osteomyelitis” as they are not synonymous
- JTF members noted some additional issues with osteochondrosis, though this is being worked on further within WHO.

16.3. **Recommended Action Items**

- **WHO** – remove *Osteoporosis and metabolic bone disease* from the MMS (though retain it in the foundation), moving *Low bone mass disorders* up one level.

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**Tuesday, 12 July 2016 – 10:06**

**17. Chapter Review - Skin**

17.1. **Background**

- WHO reports that clean-up is underway on issues such as the residuals and the “windows”.
  - Importantly, the concern with the residuals is that many of the automatically generated residuals were suppressed, being either left out completely or replaced with hard-wired foundation residuals. 
    As the classification evolves, this sometimes results in conflicts, such as index terms that cannot be indexed to any entity.
- WHO also reports that multiple parenting was implemented here more extensively than in any other chapter thanks to the hard work and proactivity of the Dermatology TAG members, but this has resulted in some instances of “windows”, including “windows within windows”, which are being addressed in accordance with the discussion at the first JTF meeting in March 2015.
- WHO confirms that there was no objections from the TAG about moving the primary parent of certain skin conditions to other chapters, such as infectious, when the etiology or origin was elsewhere and the manifestations are in or related to the skin, provided that the secondary parent link remains in the Skin chapter. In this way, the links for the DRM specialty linearization can be maintained.
17.2. Key Discussion

- JTF members noted that, even prior to this decision, the majority of infections in the skin were already in the infectious diseases, and only a few that specifically effect only the skin were parented in the skin chapter.
- JTF members commented that the titles of the structure in the Skin chapter are incorrect. For example, they are not “bacterial infections effecting the skin”, but rather “CERTAIN bacterial infections effecting the skin”, as not all bacterial skin infections have been parented here. The titles should be changed to be sure they are more accurate.
- JTF members questioned what was perceived as a lack of distinction in the implementation of multiple parenting between what is a parent and what is an associated condition.
- JTF members asked whether or not WHO is confident that this chapter can be re-shaped to be consistent with MMS recommendations, both for the chapter and for the MMS, overall. JTF members suggested that, at present, this chapter still reads as a specialty adaptation and not a general chapter for use in international reporting.
- The JTF members suggested that the priority for this chapter for Tokyo should be on fixing the hierarchy and fixing the windows. Correcting other issues are a slightly lower priority, and perhaps could be done in the post-October period.
- A JTF member raised a concern about the use of genetics as an axis, as this is not always relevant or known, and might be in conflict with other axis. In particular, this may cause issues in the future when more information is known about the genetic considerations, and how this might require the classification to change to accommodate. Is this a desirable future? Does this not create non-mutually exclusive categories?
  - There was a suggestion that the classification could mention genetic information when the conventional clinical knowledge identifies it, but that the classification does not attempt to reorganize itself to fall in line with genetic etiology.

17.3. Recommended Action Items

- WHO – retitle the groups in the Skin chapter to be “CERTAIN” XX infections affecting the skin.
- WHO – continue to address the issues of residuals and windows

Wednesday, 13 July 2016 – 9:00

18. Chapter Review – Nervous System

18.1. Background

- The Nervous system chapter was reviewed by a small group of JTF members and observers in a break-out session.
- WHO reported that there were some chapter-wide issues, such as in the generation of concepts where the manifestation / symptom is sequenced before the disease in the code title (e.g. Chorea in Wilson Disease). At the same time, the disease (e.g. Wilson disease) is actually represented elsewhere, such as in the Endocrine chapter.
- Another issue was the excessive number of categories with precoordinated entities where the external cause and/or disease could be post-coordinated or clustered (e.g. Dementia due to Toxins, Epilepsy due to injuries of the head). Some of them cannot be post-coordinated, however, as the condition does not exist elsewhere (e.g. epilepsy with mesial temporal sclerosis).
- Other specific issues included:
  - Illogical category titles (radiation-related is classified as a toxin)
  - Inconsistent shoreline (places where types 1, 3, and 4 are included, but 2 is not)
  - Unnecessary depth for some well-known or common conditions (e.g. Guillain-Barre syndrome, Huntington chorea) which results in them being “hidden” in the hierarchy etc.)
  - Possible duplications (e.g. cyclic vomiting syndrome, benign paroxysmal vertigo, lumbosacral radiculoplexy, etc.)
- In some notes, a clinical check is recommended to determine whether or not the clinical entity is recognized and common and needs to have a unique code in the MMS.

18.2. Key Discussion

- In the places where the manifestation / symptom is sequenced before the disease in the code title (e.g. Chorea in Wilson Disease), the JTF recommends moving some of the clinical manifestations into the Symptoms, Signs, and Clinical Manifestations chapter. The rationale for this move was that although these manifestations are sometimes neurological in origin or expression, that is not exclusively the case.
- JTF members noted that there is inconsistency in which entities are assigned a code (which is based on whether or not the entity is identified as a “group” in iCAT). Previous decisions at the first JTF meeting in March 2013 in Geneva Switzerland did clarify that ALL entities must have a code, though some
codes will be invalid, e.g. not permitted to use for coding. To clarify, the rule is that if an entity has
children in the MMS hierarchy, it is an invalid code and individuals must code to the subordinate level.

18.3. **Recommended Action Items**
- **WHO** – enact the decision to have a code at all levels, marking the codes invalid, as necessary, if still agreed.
- **WHO** – move manifestations into the Symptoms, Signs, and Clinical Manifestations chapter for use in post-coordination except in cases when the stem does not exist. This action item recommendation was later altered (see 20.3).

**Wednesday, 13 July 2016 – 9:20**

### 19. Chapter Review – Developmental Anomalies

#### 19.1. **Background**
- The Developmental anomalies chapter was reviewed by a small group of JTF members and observers in a break-out session.
- **WHO** reported some minor issues with the chapter, such as
  - inconsistent code titles (e.g. congenital hypoplasia of lung vs. pancreatic hypoplasia),
  - presence of neoplasms as index terms in this chapter, and
  - underutilization of the potential for post-coordination, particularly for laterality
- Additional issues identified were areas of the hierarchy where there could be “flattening” of the structure, with removal of some unnecessary anatomical subcategories to reduce complexity and to organize the concepts in a different way.

#### 19.2. **Key Discussion**
- JTF members suggested that the section on “structural developmental anomalies of the nervous system” will require a clinical view as there appears to be overlap in categories and the logic of the organization was not immediately clear.
- Regarding the anatomical groupings, JTF members noted that this chapter is inconsistent with other chapters. For example, this chapter places “mouth and tongue” as a part of the face, while other chapters include it as a part of the digestive system.
- JTF members noted that one entity, “congenital heart or great vessel related acquired abnormality”, has 68 index terms. This should be reviewed to identify which of those terms should be independent entities, or how to better organize these terms.
- JTF members noted that there are post-procedural complications in the developmental anomalies chapter, and that this is undesirable as it is inconsistent with the treatment of post-procedural complications in other chapters.
- Consistent with decisions taken earlier in the week, JTF members suggested that there are unnecessary levels of hierarchy, and that these should be removed.
- JTF members questioned the need for the level of precoordinated specificity with regard to cleft lip and cleft palate, among other things, and suggested that some of this could be represented with post-coordination. There was acknowledgement that this may have already been discussed, either with the TAG or with other expert groups. A similar issue was related to the dental conditions.
- It was suggested that the category of multiple developmental anomalies should be simplified, as this has been expanded significantly from ICD-10 and it was not clear to the JTF if all of the included detail should be required for international reporting.
- JTF members noted some questions about the group of “Conditions with disorders of intellectual development as a relevant clinical feature”.
- JTF members noted inconsistency in the entities that identified long and short arm chromosome deletions/duplications and requested additional clinical review.

#### 19.3. **Recommended Action Items**
- **WHO** – arrange for a clinical review of the section on “structural developmental anomalies of the nervous system” and “Conditions with disorders of intellectual development as a relevant clinical feature”.
- **JTF** – consider moving “mouth and tongue” to the part of the hierarchy on digestive system rather than face
- **WHO** – review index terms for places where it is excessive
- **JTF** – further consider where items might be post-coordinated

**Wednesday, 13 July 2016 – 9:40**
20. Chapter Review – Symptoms, Signs and Clinical Manifestations

20.1. Background
- The Symptoms, Signs, and clinical manifestations chapter was reviewed by a small group of JTF members and observers in a break-out session.
- WHO reported that issues raised included,
  - inconsistent exclusions,
  - issues with parenting,
  - the use of “functional” manifestations to indicate the manifestation NOS, or using “functional” to indicate idiopathic,
  - scattering of the concept of “vertigo” across multiple chapters with incorrect parenting, and
  - a need to add exclusion terms to distinguish developmental conditions from those that are manifestations of other diseases.

20.2. Key Discussion
- JTF member review noted that the top level grouping used is better than the one used in ICD-10.
- The review also positively noted the subcategory splits for Signs and Symptoms, Abnormal findings, and clinical manifestation.
- In terms of the section on “blood”, there were concerns from JTF members about two of the clinical manifestations, e.g. anaemia in chronic disease and anaemia in acute disease. It was suggested that these could be post-coordinated, if there were no objection from the Haematology Working Group or the Internal Medicine TAG.
- JTF members noted that the list of Signs and Symptoms is too detailed and should be simplified.
- The review by JTF members noted that it was difficult to create “general” rules for the chapter, such as which should be the default when there is the potential for something to be both a symptom and a manifestation.
- JTF members suggested that this is one of the chapters that will require a line-by-line review to be ready for Tokyo.
- A JTF member questioned the organization of having a section “for each chapter”, as some items that are in a specific chapter may actually be relevant to other body systems or chapters, as well.
- A JTF member raised the question of moving the clinical manifestations back to the body systems chapter, particularly given the advent of post-coordination. This would not apply to the signs and symptoms, which obviously must remain in this chapter.

20.3. Recommended Action Items
- KN – discuss the two clinical manifestations (anaemia in chronic disease and anaemia in acute disease) with the Haematology Working Group of the Internal Medicine TAG to see if there is evidence that would indicate that these two could not be removed.
- WHO – ensure a line-by-line review of the Symptoms, Signs, and clinical manifestations chapter.
- WHO – use the coding tool to “run ICD-11” against itself, to see where there might be duplications / concepts using the same terminology.
- JTF – to identify any duplicates in any area, particularly “conceptual duplicates” where the concept is represented using different names / terms, and cannot therefore be identified through any existing automated reviews.
- WHO – change the primary parent of the clinical manifestations for each chapter to the body systems chapter
- WHO – engage in a process to minimize “pairs” of categories where one is a manifestation while the other is a symptom to avoid ambiguity.

Wednesday, 13 July 2016 – 11:07

21. Chapter Review – Factors

21.1. Background
- WHO reported that, though historical decisions included the concepts of ‘family history of’ and ‘personal history of’ as addressed through the use of extension codes to reduce the number of code possibilities, this decision has been overturned. The rationale and mechanism for collection is as follows:
  - Due to the fact that some data collection systems may not collect the extension codes, these extension codes have been deleted and moved back into the precoordination space.
  - If a history of a condition cannot be identified adequately using the precoordinated codes, the cluster mechanism will be used, including the code for ‘history of other specified condition’ and the condition, itself.
WHO reports that there was also an extension code for ‘screening and evaluation’. It has been deleted as it may not be collected consistently.

WHO shared with JTF members that there is advocacy from the Quality and Safety TAG to include certain categories for adverse incidents (not events) that do not result in harm, but which are certainly relevant from the patient safety perspective.

WHO acknowledged that a major selling point of ICD-11 was the extension codes, particularly the administrative extensions. However, there was concern that some systems will not accommodate for extensions.

21.2. Key Discussion

- With regard to the inclusion of codes for instances in which a medical mistake is made but there is no resultant harm, JTF members clarified that there should be a focus on codes which are relevant to a requirement for care provision, particularly in the hospital system. If there are items which are irrelevant and make no change to the patient situation, these should, perhaps, not be collected here.
- JTF members noted that, historically, the factors chapter was explicitly not mandated for use in international reporting.
  - WHO confirms that this language has been deleted from the Reference Guide (Volume 2) for ICD-11, but recognizes that it is possible that Member States may continue to do as has been done in the past, and not use the chapter for international reporting.
- JTF members suggest to WHO that the JTF does not recommend any specific difference in the handling of the factors chapter as compared to any of the other chapters, particularly as it relates to international reporting. JTF members also recognize that the choices of Member States may be based on national requirements and not on the recommendations of this group.
- A JTF member raised a question about why the extension codes are a chapter, as this does not sufficiently clarify that these codes are different from the other chapters in terms of how they are used. Alternatively, it was suggested that this should either be chapter 1 or be included as a “supplementary classification”. This suggestion was not further addressed. This will need to be discussed further.
- WHO confirms that it is not expected that extension codes will be mandated for international reporting.

21.3. Recommendations or Decisions

- WHO – recall the JTF recommendation that there be no specific difference in the handling of the factors chapter as compared to any of the other chapters, particularly as it relates to international reporting. Maintain the language in the Reference Guide (Volume 2) as now with regard to this topic.

Wednesday, 13 July 2016 –11:40

22. Chapter Review – Pregnancy and Childbirth

22.1. Background

- WHO reports that there is a new group titled Unanticipated complications of medical and surgical care complicating pregnancy, childbirth, and the puerperium in this chapter.
  - This creates conflict with new external cause codes describing the mechanism of injury - Obstetric procedure associated with injury or harm in therapeutic use
  - It also raises a question about where causes of injury during obstetrical procedures should be classified e.g. During a caesarean section the uterine artery is lacerated
- WHO drew the attention of the JTF members to the fact that many post-procedural complications and injuries have been included in this chapter. There are different options for how to deal with this overlap with other chapters.

22.2. Key Discussion

- JTF members reviewed proposals for dealing with overlap that originated with the GURM TAG and another which originated with the Q&S TAG, noting that Q&S TAG has made efforts to develop a standard way for dealing with procedural harm across the classification.
- JTF members were concerned that some simple conditions might require many codes in order to represent a single, fairly simple condition, given the requirements of the pregnancy situation.
- A JTF member asked whether or not there would be a code for caesarean section complication in ICD-11.

22.3. Recommended Action Items

- WHO – remove the ”complication of medical care code” from the obstetric chapter
- WHO – Change the title of the procedural harm code to include caesarean section and other obstetric procedures.
- JTF – review the links between the pregnancy chapter and the perinatal/neonatal chapter to eliminate duplications and insert exclusion notes where appropriate and necessary.
23. Chapter Review – Perinatal

23.1. Background
- WHO confirmed that the feedback was received just before the meeting, and will be reviewed and implemented shortly. If there are additional questions arising from the feedback, the reviewers and the JTF will be contacted, as necessary.

24. Chapter Review – Mental & Behavioural

24.1. Background
- WHO confirmed that the feedback was received just before the meeting, and will be reviewed and implemented shortly. If there are additional questions arising from the feedback, the reviewers and the JTF will be contacted, as necessary.
- WHO also confirmed that it is likely that further guidance may be necessary, given the complexity of the content area.

25. Chapter Review – Digestive

25.1. Background
- Feedback received but not yet addressed. Additional feedback has been requested as only one JTF member was available for the review
- WHO identified some specific questions, including:
  - At present, the chapter is organized based on a primary axis of anatomical location, which does not address those conditions that may occur in overlapping sites. In these cases, the item was primarily parented under the “first” site listed in the hierarchy. Should this remain, or should an additional “overlapping site” group be created?
- WHO clarified that the proposal is not to change everything, but to add an additional group to accommodate for the conditions effecting overlapping sites.
- The Digestive system chapter was then taken into a working session for review by a small group of JTF members and observers in a break-out session to address the issue identified above.
- The discussion of the working session was based on the advice that some conditions should be listed by condition, first, rather than by anatomy, as there are times when the site is not specified or there is overlap in sites, e.g. diverticular disease or ischemic conditions, as well as ulcers and inflammation
  - Defaulting was not seen as desirable, and statistical aggregation is complicated by this.
- Options were identified for how to move forward, namely.
  - Re-order the chapter to be more consistent with what was done in ICD-10, making broader anatomical groups and exceptions for some diseases which are grouped by the disease
  - Create special high-level groupings for
    - Site not mentioned (e.g. diverticulitis, NOS)
    - Overlapping site (e.g. gastroduodenal ulcer, ischemic, etc.)

25.2. Key Discussion
- Both JTF members and WHO were clear that the work done by the Gastrointestinal Working Group of the Internal Medicine TAG is excellent, and that the concern is primarily with the organization and the implied “defaulting”, rather than with the content, itself.
- JTF members reiterated previous decisions that ICD-11 does not have “defaulting” to the same extent or in the same way as did ICD-10.
- JTF members raised a concern that, with this current structure, many records will end up in the residuals at chapter level when the site is either not known or not specified, which is not desirable.
- JTF members also raised that placing infections in specific sites is, in most cases not ideal, as the vast majority of infections are not specifically limited to just one section of the digestive system or another.
- One JTF member raised the concern that the Gastrointestinal Working Group feels very strongly about maintaining the structure as is and suggested that this is too late to make such changes, though others noted that there have been concerns about this hierarchy dating back for some time and that previous efforts have been made to address these concerns.
- JTF members recognized that this conflict is part of the reason why the JTF exists – to advise WHO on how to resolve differences of preference or opinion between experts based on evidence and use. It was suggested that there should be a coding/mapping exercise using existing data to see how the proposed structure will work, though with the caveat that there is very limited time in which to complete such an exercise using real data.
During the working session, JTF members recognized that there are substantial issues with the chapter in its current format; not at the detail level, but rather the organizational principles. Again, not for all entities, but for a specific set of them.

- Working session participants noted that the entities for which the organization is a problem would also disrupt statistical aggregation, such as diverticulitis, site unspecified would get put into “other specified disorders of the digestive system”, rather than with diverticulitis.

- At the same time, the JTF agreed that there are problems and that this necessitates finding a resolution.

- A JTF member shared that the Work Group who developed this structure believed that when a condition was not in a specified site, or was in multiple sites, the code should be defaulted to the most superior location in which it might occur. Recognizing that this might not be the best way to move forward, there should still be an understanding that this is very late in the process and a concern was raised about trying to make sweeping changes at this point.

- JTF members were clear that there will be no disrespect to the advice offered by the Work Group to WHO when making the advice of the JTF to WHO, but that there must be some advice regarding changes the JTF feels are necessary to address the use cases for ICD-11.

- JTF members acknowledged that there was a very reasonable rationale behind the current chapter design.

- JTF members confirmed that there is a desire to accept the advice of the WG to the extent possible, focusing primarily on those items within the proposal that do not currently work for the broader perspective.

- A JTF member suggested that if we create an “overlapping site” category, it could be difficult to tabulate later, as the conditions would be scattered between the different categories. As such, perhaps the first option listed in the background would be more appropriate.

- JTF members favoured the first option listed on the sheet, with the caveat that there were concerns about the amount of time available to implement the changes
  - Stomach and duodenum combined
  - Rest of small and large intestine combined

- The advice from the JTF to WHO is the JTF believes that the current framing of the digestive system chapter is sufficiently problematic to justify a need to reorganize it.

- WHO accepts this advice, and acknowledges that there may be some additional refining through testing

- JTF members and WHO confirm that the level of detail represented in the chapter is very welcome and well-done, and will not be changed. It is only the tabulation order which will be adjusted to address the concerns.

- JTF members further discussed, and settled on a recommendation to WHO to enact the proposal to include an additional group to accommodate for the conditions that are relevant to more than one site.

**25.3. Recommended Action Items**

- **WHO** – enact the proposal to include an additional group to accommodate for the conditions that are relevant to more than one site.

- **WHO** - Provide a list to the JTF of which conditions would be primarily in this new group for processing in a future teleconference. No specific timeline was set.

- **JTF** – review the proposal to ensure agreement with the proposed list of conditions to be primarily parented into the new group.

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**Wednesday, 13 July 2016 – 13:34**


**26.1. Background**

- WHO reported on the changes that have been made to the Reference Guide (Volume 2) since the Koln meeting. These include:
  - Update of the taxonomy section with the edited text from the merged taxonomy –structure document
  - Update the mark-up and all the references for clustering
  - Update the description with the definitions agreed at the taskforce
  - Update the description of functioning properties to explain prior practice for sub-setting, and the recommendation to use the full ICF, where possible
  - Remove redundancies regarding joint use of ICD and terminologies
  - Removed redundancy regarding special tabulation lists, and added new ones
  - Edited mortality rules for
    - Internal references
- Examples to comply with new structure and post-coordination (issues to be discussed on how to post-coordinate in mortality;
- Proposed: apply linkage rules, but stay otherwise on single line of certificate
- Amended neoplasm rules to work with new neoplasms structure
- Death certificate form
- Removed references to ICD-10 codes
  - Edited morbidity rules for
  - Internal references
  - Examples to reflect the post-coordination coding (please check consistency
  - Edited Morbidity rule definitions for errors
  - Chapter specific examples
  - With prior input from Bill Ghali, the rules for coding postoperative complications
  - Removed references to ICD-10 and some tables that need to be regenerated when the coding structure and transformation of the file is complete

26.2. Key Discussion
- Regarding the use of post-coordination in Mortality, the JTF is preliminarily supportive, but not yet willing to actively recommend it. There is a preference to have more consultation on the topic.
- JTF members suggested that it would be inappropriate to have a statement indicating explicitly that post-coordination should not be used in mortality, but also inappropriate to have a statement at this point that it should be used. However, the JTF members accepted the suggestion that the Reference Guide (Volume 2) could include some language which might foreshadow such future use.
- A JTF member clarified that the FDC is considering updating the “family paper”, positioning the family in the ICD-11 era, and this should also be potentially considered in terms of updating the Reference Guide (Vol 2)

26.3. Recommended Action Items
- WHO – review the text to address the concerns expressed above about using post-coordination for mortality.
- WHO – Send the word doc version of the Reference Guide (Vol 2) to the JTF
- JTF – Provide feedback to WHO via track changes on the document by 15 August 2016.
- WHO – Incorporate the feedback once received, as appropriate.
- FDC – Publicize the “family paper” once available.

Thursday, 14 July 2016 – 10:00
27. Mapping System Demo
27.1. Background
- The WHO presentation confirmed that it is necessary to log into the browser in order to access the mapping tool. All those with access should be able to view the mapping output, though if this is not the case, please contact WHO.
- Information about the mapping tool included:
  - Mappings are done at the foundation level so that the inclusion or not in any given classification, such as the MMS, or any changes that are made can be accommodated for.
  - The mapping tool shows three panes of information, with ICD-11 on the left and ICD-10 on the right, and a center pane which outlines the equivalence of the mapping. This can be a one-to-one map, or a map in which one entity is broader or narrower than the equivalent on the other side, as well as one-to-multiple or multiple-to-multiple maps.
  - In some places, there will be no mapping available, as there is no equivalent. In this situation, the system does still advise where the concept would be coded in the absence of the map.
- WHO confirmed that much of this work has already been done, and the expectation is that we will have a very reasonable, fairly complete map prior to Tokyo
27.2. Key Discussion
- JTF members raised a question about whether or not this tool could be used to do the mapping for national clinical modifications, known as XM versions, of the classification. WHO confirmed that although it was theoretically possible, this would require creating a new version of the tool with the XM version loaded instead of the ICD-10 international version, with the subsequent work to verify, expand, and correct the mappings.
- JTF members were clear that WHO would not be expected to take on the workload associated with building the mappings for the XM versions
A JTF member asked about the translation tool and use of this, particularly for those languages that are not WHO official languages. WHO confirmed that this is possible, but it does require certain resources and files in order to work.

Thursday, 14 July 2016 – 10:20

28. Functioning Properties

28.1. Background

- WHO confirmed that functioning properties are of interest and relevance to the JTF, but are also a wider issue for consideration across ICD-11. As such, the interest of many stakeholders was acknowledged.
- WHO provided an overview of the recommendation of the RSG-SEG to WHO, with particular links to how this might either reinforce, modify, or contradict the proposal made previously by fTAG with feedback from additional individuals.
- The RSG-SEG process included:
  - A series of 5 "special sessions" specifically dedicated to the topic
  - A review of the 71 pages of feedback offered by individuals within the network (RM, RM, AM, LF, HtN, and CS) as well as the responses from fTAG
  - Some individual discussions with individuals involved in providing the feedback.
  - A review of the initial draft and the updated draft which reflected this feedback
  - Brief testing of the proposed rules and examples using local coders and gathered feedback.
  - Feedback to the fTAG and FDRG co-chairs through the WHO liaison at face-to-face meetings and monthly teleconferences.
- The key components of the RSG-SEG advice included:
  - Functioning properties values should be available for use via the post-coordination mechanism (consistent with the compromise proposal)
  - Although it is possible to include all of the activities & participation concepts in the ICD-11, it is not desirable to include all (nearly 500) concepts in the MMS, as it will be too much of a burden to users. (partially consistent)
  - The 21-item rehabilitation / disability set seems appropriate, but RSG-SEG requested fTAG feedback to confirm. (partially consistent/consistent with earlier proposal)
  - The binary coding mechanism, which represents "nested post-coordination", or using an extension code to modify an extension code, is inconsistent with other rules and should be dropped. (inconsistent with proposal)
    - To be consistent with general ICD use, entities should be coded ONLY when present
    - The ability to qualify the severity of impact on the function is desirable. (consistent with proposal)
    - RSG-SEG proposes making the functioning properties stem codes and using extension codes to identify "severity of impact/limitation". (modification of proposal)
    - RSG-SEG suggests that the existing "mild-moderate-severe" values could be used. (new item, preliminarily agreeable to fTAG pending further information)
    - RSG-SEG recommends including the short-list of functioning properties as stem codes in the chapter titled Symptoms, signs, clinical manifestations, and abnormal clinical and laboratory findings. (new item, preliminarily agreeable to fTAG pending further information)
      - Codes should have sanctioning rules indicating when (and which) FPs are most appropriate for use with given conditions, including using the ICF Core Sets. (new item, preliminarily agreeable to fTAG pending further information)
- RSG-SEG suggested that the recommendation had the following benefits:
  - The existing mechanism allows for the post-coordination of two stem codes together
  - Including functioning properties as stem codes would allow individuals to
    - optionally use a severity extension to qualify the functioning property value selected
    - Codify the patient's self-reported reason for encounter, which is often the entry point of the interaction with a provider
    - Code functioning information without much additional burden, as this adds just 21 entities to the MMS
  - Implementing this recommendation would increase the likelihood of the use and implementation of functioning properties in countries, as post-coordination is optional
- However, WHO reported the following items still to be addressed:
  - A review to verify any coding rule issues / conflicts
  - Verification with fTAG about the proposed shortlist of 21 functioning property values
  - Removal of the non-ICD relevant information about ICF and functioning properties from the Reference Guide (Vol 2)
  - Redrafting the coding examples so they are more consistent with the other ICD coding examples
- Develop definitions/descriptions & fully specified names for each functioning property value
- JTF response to the RSG-SEG recommendation to WHO

WHO has received and is considering the recommendation of the RSG-SEG, but explicitly requested the feedback of the JTF on this item in follow-up to the conversation at the Koln meeting in April 2016.

28.2. Key Discussion

- JTF members confirmed that the referral to the RSG-SEG was made because it was clear that there was some disagreement with the proposal put forth by fTAG. At the same time, JTF members acknowledged that it is within the authority of RSG-SEG to determine how they will handle issues once they are raised.
- A JTF observer shared a presentation that had been prepared in advance with a series of alternate proposals for how functioning properties should be represented. These included:
  - Maintenance of multiple coding options for functioning properties, including
    - Using the 21 titles of the chapters and blocks of ICF’s Activity and Participation (A&P) codes as the short-list
    - Using a tailored set of functioning properties (as identified in the ICF Core Sets) through a “drop down list” that can be selected by users if desired.
    - Using an alternate list of 23 activities and participation codes as the short list.
  - Inclusion of the functioning properties in the Factors influencing health status and contact with health services chapter, rather than the Symptoms, signs, clinical manifestations, and abnormal clinical and laboratory findings chapter, as capability codes have already been added to this chapter, and as the Symptoms, signs, clinical manifestations, and abnormal clinical and laboratory findings does not include the concept of functioning at this time.
  - Alternatively, not including the functioning properties as stem codes at all, rather putting them into the extension codes
- JTF members acknowledged that it appears as though a resolution is very close, and suggested that if the functioning properties will be included in the Symptoms, signs, clinical manifestations, and abnormal clinical and laboratory findings chapter, the title should be changed to include “functioning properties” or “functional impact” in the title.
- JTF members raised a concern that the factors chapter contains entities that causes an individual to seek a service, or a factor not due to a current injury or illness, and suggested that there could be concerns about including functioning properties here, as well.
- A JTF member suggested that it would be better to include functioning properties in the Symptoms, signs, clinical manifestations, and abnormal clinical and laboratory findings chapter, as they are a description of health, but not a health condition, which is similar to the other entities in that chapter.
- Another JTF member suggested that the Symptoms, signs, clinical manifestations, and abnormal clinical and laboratory findings chapter is consistent with how cluster coding is being used for other clinical manifestations.
- Another JTF member agreed with the RSG-SEG proposal, suggested that this information is important, and it is sometimes “what the patient reports”.
- A JTF observer raised a concern about using functioning properties as extension codes, as there might be many functioning properties relevant for a given condition, creating an extraordinarily complex code, or causing them to not be used at all. It was suggested that having them as stem codes actually makes them much easier to use.
- A JTF member raised a concern about who will assign the functioning property codes, and if coders would be asked to make this determination from the record. WHO confirmed that coding will be done as always, if the information is explicit in the record, it can be coded. If it is not explicit, it should not be assumed.
- Another JTF member raised a concern about governance, and how updates to ICD might result in a split from the concepts as mapped to ICF, or vice versa.
  - WHO confirmed that this is not expected to be a huge issue, as the updates of both classifications are handled in the same group with feedback from the relevant parties. Furthermore, it is unlikely that items would be changed (as “walking” is hard to update), while the addition of new functioning properties or the elimination of ones deemed unnecessary would not cause any problem.
- JTF members agreed that, at this point, the question was more an issue of how to include functioning properties in the MMS, rather than if they should be included.
- JTF members agreed that the ICF qualifiers were not suitable to the ICD use case and should not be used to qualify severity or other aspects of the functioning properties.
• JTF members confirmed that the “where”, e.g. in the Symptoms, signs, clinical manifestations, and abnormal clinical and laboratory findings chapter or in the Factors influencing health status and contact with health services chapter, was less problematic, acknowledging that an argument can be made for either option.
• JTF members confirmed, however, that they should be grouped together and not scattered into individual body system chapters.
• JTF members suggested that functioning properties can be considered as a reason for encounter, or like a sign when something “doesn’t function”.
• JTF members suggested that some of the confusion about using the classifications together might be addressed in the updated Family paper.

28.3. Recommended Action Items
• WHO – update the title where the functioning properties stem codes will be located to ensure that the title accurate represents the contents within the chapter, when the chapter is selected.
• WHO – disseminate the updated information
• WHO – engage with fTAG about the recommended shortlist to see if an opinion can be elicited and share that opinion with RSG-SEG and JTF.

28.4. Recommendations or Decisions
• JTF recommends that the functioning properties shall be stem codes.
• JTF recommends that the functioning properties shall be grouped together in the hierarchy.
• JTF does not have a recommendation at this time whether the functioning properties should be in the Symptoms, signs, clinical manifestations, and abnormal clinical and laboratory findings chapter or in the Factors influencing health status and contact with health services chapter
• JTF recommends including just a subset of activities and participation in the ICD-11-MMS
• JTF does not have a recommendation at this time what that subset should be.
• JTF does not have a recommendation on the question of governance of functioning properties at this time.

Thursday, 14 July 2016 – 12:05
29. Postprocedural Complications

29.1. Background
• WHO confirmed that the decision in Glion was that chronic or permanent conditions that result from an intervention will be classified in the appropriate body system chapter. Acute conditions are in the injuries chapter.
• Conditions that result from a device reaching the end of its expected life span (e.g. pacemaker battery reaching the end of its charge), will also be classified in the appropriate body system chapter.
• WHO confirmed that the Quality and Safety TAG has agreed to help with the decisions about the appropriate body system for each complication.
• As a part of this decision, codes for mechanism can be optionally clustered.
• WHO confirmed that the goal was to eliminate the confusion that existed in ICD-10 due to the concepts of early or late complications.
• WHO further clarified that acute events will be classified using the cluster mechanism with a code from the appropriate chapter (could be an injury) along with the mode and mechanism.
• Regarding adverse events, WHO confirmed that health-care related events that do not result in harm (e.g. a near miss) to the patient were not classifiable in ICD-10.
  - However, several categories addressing adverse events that do not result in harm, may be added to the Factors chapter (Chapter 24) in ICD-11.

29.2. Key Discussion
• JTF members recalled that the model proposed by the Quality and Safety TAG is outlined in the Reference Guide (Volume 2). JTF members are asked to review this to ensure that the description is consistent and acceptable as a part of the general Reference Guide (Volume 2) review.
• JTF members asked about the section of codes from ICD-10 on “misadventure”, and if these will be maintained and a distinction made.
• JTF members noted with approval the efforts to remove pejorative language from ICD-11.
• JTF members confirmed that the chronic conditions resulting from an intervention will be in the relevant body systems chapter in a unique group.
• A JTF member queried the difference between hypothyroidism that was postprocedural as compared to non postprocedural, and why this would not be represented potentially with the code “acquired hypothyroidism”, with a cluster for etiology.
WHO confirmed that this is based on the information that is to be collected, and conflating post-procedural hypothyroidism with hypothyroidism that is randomly acquired is not desirable for the quality and safety public health use case. This remained a concern, given that users might be confused about which option to use.

- Another JTF member raised a concern that non-issues would still be coded as postprocedural conditions which might negatively affect the provider in a way that is unjustified. This could be exacerbated by the presence of a “postprocedural” extension code. These and other issues may require further consideration.

### Thursday, 14 July 2016 – 12:26

#### 30. Next Steps

**30.1. Background**

- WHO reported that there are some outstanding issues related to the Revision Conference, particularly with regard to confirming speakers and ensuring consistent and clear communication of key messages designed for representatives of Member States.
- WHO confirmed that the October Release of the ICD-11-MMS will be for Member State (MS) comment, while still undergoing quality assurance
  - The goal of Member State feedback is to ask their views on the ICD-11, understanding that they may not get into the specific details or lower level codes.
  - WHO specifically desires their views on future data needs, particularly in more complex conditions, in the context of ageing, etc. and how the technical construct must support this.
- WHO particularly would like to elicit requirements for how the technical construct will support and interact with potential future XM versions
- WHO is also interested in focusing on how to get the Family of International Classifications to work more seamlessly in the new environment from the MS perspective of interest
- WHO confirmed that, to address the JTF work and the technical detail of ICD-11-MMS, there will be several JTF sessions, including one open session for all WHO-FIC members. Items of more technical detail than is relevant for the ICD RC should be discussed here.

**30.2. Key Discussion**

- In terms of the open session, a JTF member suggested that it was correct to think that a session for the full network on more detailed items would be desired and appropriate.
- In the context of the WHO-FIC meeting, JTF members acknowledged that it might be slightly risky for this group that has been intimately involved, to simply say that things are going well. It might be better if some of the highly respected individuals from outside this group were able to give their positive experiences. It was suggested that this group might be able to suggest or nominate individuals for these positions.
- Another JTF member suggested that the kind of presentations done here, such as live demonstrations of the post-coordination mechanism implementation, would be interesting and useful.
- JTF members were also clear that, given the recommendations from this group to change some previous actions, it might be useful to face this directly and meet with TAG and Work Group members.
  - Another JTF member suggested a F2F meeting of those TAG and Work Group members who are able to attend Tokyo.
- JTF members suggested that at least one session could be dedicated to standard business of the JTF, looking at the plans for the year after October.
- It was clarified that items such as “joint use of classifications” is within the mandate of the FDC, and it might be confusing to try to also address it in the JTF meeting from the MMS perspective.
- However, this group may be interested in discussing how to link this work to the monitoring of the Sustainable Development Goals (SDGs).
- JTF members specifically recognized the extraordinary work done by a very small group of individuals, much of this resting on the team in Geneva, supplemented by the work of individuals around this table and the teams at their institutions.

**30.3. Recommended Action Items**

- **JTF and WHO** – prepare the agenda for the Tokyo sessions of the JTF, considering the feedback above