

WHO-FIC Morbidity Reference Group Meets in Banff, Canada

The WHO-FIC Morbidity Reference Group met for two days in beautiful Banff in Alberta, Canada in April 2018. Attendees represented Canada, Sweden, Australia, United Kingdom, Germany, USA, Japan, Thailand, Finland, and Korea. Reviewing and revising the ICD-11 Reference Guide was a key objective of this meeting. Specific topics included the post-coordination feature in the ICD-11 browser and how it aligns with the definition of post-coordination. Cluster coding in general was discussed, as well as the codes that would comprise a cluster in the case of multiple injuries. Cluster coding refers to an ICD-11 convention used to show more than one code used together to describe a documented clinical concept.

Sequelae codes need to be part of the stem codes (i.e., codes that can be used alone) rather than extension codes since the extension codes are optional. Extension codes should never be used alone and must always be linked to a stem code. They are provided for use as supplementary or additional codes when it is desired to identify more detail than is included in the stem code. For example, when coding malignant neoplasm of upper-outer quadrant of the left breast in ICD-11, “malignant neoplasm of the breast would be the stem code,” whereas “left” and “upper-outer quadrant of breast” would be extension codes that may be linked to the stem code to capture additional detail about the site.

Various options for code placement for sequelae codes were considered, including the “personal history” code section. Some attendees objected to placing sequelae codes with “personal history” codes, as “personal history” has a specific meaning, referring to the fact that a patient’s past medical condition no longer exists and is not receiving any

treatment, which is quite different from sequelae. A sequela is the residual effect after the acute phase of an illness or injury has terminated.

The group agreed that clear definitions of instructional notes are needed, such as “code also” and “use additional code” notes. Consistent use of unambiguous linkage terms is also important. For example, “due to” clearly indicates the existence of a causal relationship between two conditions, whereas “with” and “in” do not.

The implications of the new clinical definition of sepsis from the Third International Consensus Definitions Task Force were also discussed. The group recommended not updating ICD-10 to reflect the new definition.

A three-part model for coding healthcare-related harms, proposed by the ICD revision's Quality and Safety Topic Advisory Group, was reviewed. This model involves a combination of codes (linked through clustering) to depict: a code describing the actual injury or harm that resulted from the event; a cause or context of harm; and a mode or mechanism of harm.

Results of a Canadian ICD-11 field trial were presented. Participants found classroom training in conjunction with coding practice on both short scenarios and complete charts very helpful in increasing their confidence in coding with ICD-11. Participants also felt more coding rules and guidance would be beneficial.

The meeting concluded with a discussion around ICD-11 transition planning. The need for a cost/benefit analysis was raised. Potential benefits of transitioning to ICD-11 relate to improved quality of healthcare data for making better decisions about patients. Cost

savings from moving to ICD-11 are difficult to prove. Considerations as countries begin to plan for the transition to ICD-11 include:

- the need for modification of any casemix or Diagnosis Related Groups (DRG) classification systems;
- impacts on the clinical coder workforce;
- impacts on statistical systems;
- education of clinical coders, clinicians and other users and generators of coded data;
- use of ICD-11 with terminologies and electronic health records; and
- technical requirements and lead time for the changes to health information systems, coding tools and casemix groupers.

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