# WHO-FIC Asia-Pacific Network Working Meeting
# Report

Date and Time: December 9, 2013 10:00-16:30 (Japan time)
Place: Japan Hospital Association, conference room
Participants: Co-Chairs - Hiroyoshi Endo and Sukil Kim
Wansa Paoin, Maliwan Yuenyongsuwan, Toshio Oi, Yukiko Yokobori

## 1. Introduction

Dr. Endo welcomed the participants. The Co-Chairs expressed their gratitude in particular to Dr. Oi for his support of the Network.

It had been agreed at the Bangkok meeting that the Asia-Pacific Network would pursue three sets of actions for its strategic workplan, namely, (1) ICD-10 simplified Asia version, (2) a survey on educational resources for ICD training in the region, and (3) development of an original core curriculum.
Participants agreed that this Working Meeting would focus on (1) production of ICD-10 simplified Asia version. The special tabulation lists that the Japan's Ministry of Health, Labour and Welfare uses for mortality and morbidity classification and Thailand's ICD-10 TM for PCU (Primary Care Units) were presented for reference.

## 2. ICD-10-TM for PCU

### 1) Introduction

ICD-10-TM for PCU has categories listed in both Thai and English and an index at the end. Dr. Paoin described the characteristics of ICD-10-TM for PCU, as follows:

(1) It does not contain categories that are unnecessary in primary care units. (For example, PCUs are not able to identify the strains of cholera bacteria and likewise for typhoid fever. Categories for different types of cholera and typhoid fever, therefore, are unnecessary). The same also applies to the alphabetical index.
(2) It deleted complicated rules that are difficult to understand.

It was pointed out that there may be a need to analyze frequently used categories in different countries when developing the APN version. It was also pointed out that although Thai traditional medicine is not included in ICD-10-TM for PCU, other countries may want to include their traditional medicine in the APN version.

Dr. Paoin explained the steps that Thailand took when developing ICD-10-TM for PCU, as follows:

(1) The number of categories was reduced by analyzing past coding data and selecting categories representing common diseases found in PCUs.
(2) Complexities were eliminated by doing away, among others, with the dagger-asterisk system and hidden coding rules. For example, *M02.0 Arthropathy following intestinal bypass* does not indicate the site affected. To express the site, one must go to the beginning of the chapter and select the appropriate site code. For arthropathy in the upper arm following intestinal bypass, the code is M02.02. In ICD-10-TM for PCU, they eliminated these kinds of hidden coding rules by attaching the site codes to the main codes in the list of categories.
(3) Confusing code descriptions were eliminated. For example, they deleted *C00.0 Lip, unspecified* because of the confusing code description.
(4) The number of index terms was reduced.

ICD-10-TM for PCU consists of the following books:
Book 1: Diagnosis
Book 2: Procedures
Book 3: Flow Chart
Book 4: Home Care

Book 2: Procedures was developed entirely in Thailand based on ICD-10-TM (Thai Modification). It has 7-digit codes, which are structured around three axes as in ICHI, as follows:

- Anatomical Axis (1st-3rd digits)
- Procedure Axis (4th-5th digits)
- Detail Axis (6th-7th digits)

For example, the code 733-11-70 can be broken down into 733, which is the anatomical site, and 11, which is the procedure performed (in this case, removal of sutures from skin of thigh). Because PCUs usually do not perform invasive procedures, it suffices that PCUs are capable of coding only those procedures performed on the outer body.

**2) Discussion**

Prof. Kim remarked that there were no specific primary care codes in the Korean healthcare system, because expertise in primary care settings enabled accurate coding using ICD. He said that private hospitals provided more than 90% of healthcare services

and that there were few public primary care centers in Korea.
In response to Prof. Kim's remarks, it was agreed that the APN version should be developed mainly for developing countries and not for countries already using ICD.

Dr. Oi asked if ICD-10-TM for PCU can capture diseseases that have greater consequence than other diseases. For example, the question pertains to whether collagen disease, which is potentially mortal, should simply be coded to *M13.9 Arthritis, unspecified*. Dr. Paoin replied that a PCU in Thailand may not be able to diagnose a patient with collagen disease, because it does not employ physicians, and the patient would be referred to a hospital for more specialized examination. He said that, therefore, there was no need to capture collagen disease at the PCU level. It was agreed, however, that as pointed out by Dr. Oi, there should be a mechanism where such diseases are captured and coded in the APN version to prevent loss of data.

Dr Paoin was shown the special tabulation lists that the Japan's Ministry of Health, Labour and Welfare uses for mortality and morbidity classification. He said that Thailand also uses similar tabulation lists and that these lists were probably taken from the ICD-10 Special Tabulation Lists.

Prof. Kim said that Korea has an automated system for tabulating groups of categories based on code structure. Matrices for inpatients can show multiple complications of an inpatient. The matrices are part of basic data that hospitals submit. Primary care centers also use a similar system.
In Thailand, some PCUs perform medical interventions, while some PCUs are engaged only in prevention and fulfilling other public health goals.

Participants raised the question of whether the Asia-Pacific Network would be allowed to use ICD-10-TM for PCU. Ms. Yuenyongsuwan assured them that she would try to obtain approval from her superior and that it was alright for the Asia-Pacific Network to use it. It was decided to clearly indicate in the APN version that it is based on ICD-10-TM for PCU.

It was also noted that Laos already uses ICD-10-TM for PCU.

A participant asked whether ICD-10-TM for PCU could always be matched with ICD-10. Thailand replied that it could, because the codes remained unchanged. A

question was raised on codes such as H02 that had been deleted. Thailand explained that they deleted *H02 Other disorders of eyelid* because analysis of past coding data did not show the use of this code in PCUs and that if H02 was required for coding in a PCU, the coder would refer to ICD-10 for coding. It was pointed out that such cases involving the handling of H02 code was probably unique to Thailand and that there was a need to do a survey in other countries to reflect the situation in those countries on the APN version.

It was further pointed out that if lead terms, such as *Other disorders of eyelid* for H02, could be maintained in the list, instead of completely deleting them as in ICD-10-TM for PCU, it may at least help coders identify locations of diagnoses that were not codable.

Dr. Paoin presented a coding flow chart used in PCUs. The flow chart is based on some 50 possible scenarios. By following individual sequences on the flow chart, a coder can arrive at the right codes. This has made the task of coding at PCUs much easier.

**3) Training**

Thailand organized more than 20 workshops this year for training in the use of ICD-10-TM for PCU, visiting each province to give three-day workshops and conducting a test at the end of each workshop.

The curriculum was as follows:

- Introductory Part
- Structure
- Which Type (diagnosis or prevention)?
- Use of the Index
- Use of the Special Tabulation Lists
- Selection of Main Conditions
- Procedure Coding
- Thai Traditional Medicine

A test at the end of the curriculum

**3. ICD-10 APN simplified version**

**1) General Concepts**

The following general concepts was agreed upon:

1. Title: ICD-10 for Primary Health Care, APN version
2. ICD-10-TM for PCU will be used as the alpha version (review by Japan, Korea and Thailand).

3. The beta version of ICD-10 for Primary Health Care, APN version, to be released in 2014

4. Simplification Rules

(A) Reduce the number of codes

Use past coding records.

Send questionnaire sheets to developing countries to collect data.

Have experts review ICD-10-TM for PCU.

(B) Eliminate complexities

Remove the dagger-asterisk system.

Use pre-coordination.

Use easy-to-understand code hierarchies.

Eliminate difficult-to-use terms and symbols.

(C) Clearly indicate lead terms and add instructions (for looking up specific diseases in ICD-10)

5. Coding Rules

(A) Write down the diagnosis prior to coding.

(B) Multiple coding is allowed. Select the main condition.

(C) Add external cause codes to injuries.

(D) Do not use the symptoms and signs codes (R codes) when a more specific diagnosis has been made.

(E) Do not use the codes for health promotion and prevention (Z codes) for patients receiving ambulatory care for particular illness.

6. Coding Guidelines

(A) Provide a flow chart of common scenarios as guidelines for diagnosis and ICD coding.

7. Training and Curriculum

(A) Prepare a draft curricum for a three-day training course.

8. Conduct field trials or public hearings after the release of the beta version

In Thailand, ICD-10-TM for PCU is used both for health insurance claims and statistics. Dr. Paoin said that decisions on how countries use the ICD-10 for Primary Health Care, APN version, could be left to those countries, which can make the decisions based on the situation in those countries.

As for the code structure, it was proposed that the APN version contain 3-character codes as well.

Prof. Kim said that drawing from experiences in Korea, it is sufficient to have 600 to 700 codes for outpatient services. Dr. Paoin said that ICD-10-TM for PCU has as many as 1,900 categories because of the need to incorporate the needs of prevention (i.e. Z codes). Due to the importance of prophylactic vaccination and other preventive measures in developing countries, it is essential to monitor these events with Z codes.

It was agreed that in the early stage of the APN version, it would be sufficient to limit the scope to morbidity and mortality. It was also agreed to use the translation software that Prof. Kim developed for translation of the APN version into respective languages.

**2) User countries**

In a discussion on the processes of developing the APN version, it was agreed that countries not using ICD or are in the early stage of introducing ICD should be considered as user countries of the APN version, which are as follows:

- Myanmar (hospitals have coding capability but not PCUs) *[Thailand]*
- Laos *[Thailand]*
- Cambodia (ICD-10 not in use) *[Thailand]*
- Vietnam (ICD partially introduced) *[Thailand]*
- Mongolia *[Korea]*
- The Philippines *[Japan]*
- Indonesia (use of ICD limited to hospitals; ICD not used in PCUs) *[Japan]*
- Bhutan (may be interested in developing a simplified version of ICD) *[Thailand]*
- East Timor *[Thailand]*
- Nepal *[Thailand]*

A total of 10 countries

It was decided to try to produce APN version that even a person who was not a physician could use. A survey is needed to identify respective countries' needs in light of the situation in those countries. It was decided that each participant will be responsible for finding contacts in the above countries (the countries responsible for finding contacts are shown after the country name above in italics).

**3) Next steps**

Dr. Paoin said that the invitation to the next meeting should also be sent to China and addressed to Dr. Aimin Liu, who is the Head of the Collaborating Centre for the WHO-FIC in People's Republic of China (the invitation had been sent to Dr. Qin Jiang

(a.k.a. Ginger) until now).
It was decided that the APN secretariat will send ICD-10-TM for PCU to the Chinese Collaborating Centre by e-mail as a reference guide and request comments on the General Concepts. The Co-Chairs will brief them on the developments to date, and the secretariat will request specific work to be done.

The participants discussed how to conduct the field trials. An issue was raised on which types of field trials to conduct. A participant indicated that a feasibility test would be appropriate, in which case countries should be invited to participate in the tests. It was agreed that if budgetary constraints made it difficult to carry out the field trials on an extensive scale, they could select one or two countries. The participants chose Indonesia and Laos as potential candidates.

**4. The 7th APN meeting in Malaysia**

The participants then discussed the topic of the 7th Asia-Pacific Network Meeting to be held next June in Malaysia. A participant requested that universal health coverage (UHC) be one of the main topics at the meeting. As for the survey on the educational resources, it was decided to ask countries if they could provide what resources they had for free as it was difficult for many developing countries to take part in educational programs unless the programs were free. The agenda will include country reports as in previous APN meetings (see the attached draft program).

WHO's participation in the meeting is unclear at the moment. It was decided that the meeting dates should be June 12 (Thu.) and 13 (Fri.), instead of June 11 (Wed.) and 12 (Thu.), and that they would request the FDC to have their three-day mid-year meeting from June 9 (Mon) to 11 (Wed.). The APN secretariat will send e-mail to Dr. Syed Aljunid to notify the date changes. Prof. Kim will then discuss with Ms. Jenny Hargreaves, the FDC Co-Chair, on adjusting the schedules of the two meetings.