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For more information, please contact:
Bridget Stratton
Public Relations
312-233-1097
bridget.stratton@ahima.org

Debunking Myths and Misperceptions of ICD-10
Journal of AHIMA illustrates why it's time for 10

CHICAGO – July 30, 2014 – In today's social, shareable society, myths spread faster than ever. Fortunately, old-fashioned facts still trump inaccurate and misleading information.

The August issue of the *Journal of AHIMA* uses evidence to dispel three of the most persistent ICD-10 falsehoods in "Myths of ICD-10-CM/PCS." The article is authored by Sue Bowman, MJ, RHIA, CCS, FAHIMA, American Health Information Management Association (AHIMA) senior director, coding policy and compliance. She is AHIMA's representative to the Cooperating Parties, a group with direct input into the creation, maintenance, and updating of healthcare codes and guidelines for their use.

The three misperceptions addressed in the article are the idea that replacement of ICD-9-CM is not a necessity; the increase in the number of codes from ICD-9 to ICD-10 increases the difficulty of using the new code set; and that SNOMED CT or ICD-11 represent viable alternatives to ICD-10-CM/PCS implementation.

"The transition to ICD-10 continues to be inevitable and time sensitive," said AHIMA CEO Lynne Thomas Gordon, MBA, RHIA, CAE, FACHE, FAHIMA. "As the healthcare industry experiences an additional delay in ICD-10 implementation, now is the ideal time to rebut ICD-10 myths that continue to percolate."

MYTH 1: ICD-9-CM is not a necessity

Replacing the "obsolete" ICD-9-CM is not optional. Bowman writes, "… Its limited structural design lacks the flexibility to keep pace with changes in medical practice and technology. The longer ICD-9-CM is in use, the more the quality of healthcare data will decline, leading to faulty decisions based on inaccurate or imprecise data."

In addition, if data on new diseases and technology or distinctions in diagnoses and procedures can't be captured, there is no basis to effectively analyze healthcare costs or outcomes. Without ICD-10, the value of investment in electronic health records (EHR) is significantly diminished, as the more comprehensive and detailed information will be lost when aggregated into the outdated and ambiguous codes in ICD-9-CM.

MYTH 2: Increasing the number of codes from ICD-9 to ICD-10 increases the difficulty of using the new code set.

While considerable attention is paid to the larger number of codes in the new code set, the major reason for the expansion is simple: 46 percent of the added codes reflect the ability to identify the affected side of the body.

More comprehensive and precise codes will actually make it easier to find the right code, just like it's easier to find the correct word in a comprehensive dictionary. Bowman writes, "…Increase in specificity, clinical accuracy and a logical structure facilitate – rather than complicate – the use of a code set." Also, much of the extra detail was requested by practitioners because the greater specificity provided value that was thought to be clinically significant.

MYTH 3: SNOMED CT or ICD-11 represent viable alternatives to ICD-10-CM/PCS implementation

Clinical terminology systems such as SNOMED CT and classification systems such as ICD-10 play separate but equally important roles in healthcare delivery. They are complementary – not exclusive – of each other.

For example, Bowman writes, "…Health records created and stored in electronic environments require the use of uniform health information standards, including a common medical language. Together terminologies and classification systems provide the common medical language necessary for interoperability and the effective sharing of clinical data. … SNOMED CT and ICD-10-CM/PCS used together in EHR systems can contribute to patient safety and evidence-based high-quality care provided at lower cost by leveraging a 'capture once, use many times' process."

Although the World Health Organization (WHO) estimates ICD-11 will be finalized and released in 2017, that date marks the beginning, not the end of the process toward adoption. For example, ICD-10 was endorsed by the 43rd World Health Assembly in 1990 and WHO member states began using it in 1994. It took eight years to develop a U.S. modification of ICD-10 and a procedure coding system and 19 years for a final rule to be published. Five years following the publication of the rule, ICD-10-CM/PCS has still not been implemented.

The process for evaluating ICD-11 for use in the U.S and developing the necessary modification to meet our country's specific information needs and developing a procedure coding system would take at least a decade; then, there would be the rulemaking process to adopt ICD-11 as a HIPAA code set standard.

- In a 2013 report, the American Medical Association Board of Trustees recommended against skipping ICD-10 and moving directly to ICD-11 for a number of reasons, including: "ICD-9 is outdated today and continuing to use the outdated codes limits the ability to use diagnosis codes to advance the understanding of diseases and treatments, identify quality care, drive better treatments for populations of patients, and develop new payment delivery models."

Also in this issue

- Four case studies developed by AHIMA are featured in the article, "Coming Soon to Your Healthcare Facility: Information Governance." The article will help HIM professionals better understand the issues associated with implementation -- including common questions and overarching goals – and encourage them to take the lead in developing similar programs at their facilities.

- The article, "Roles for HIM Professionals in HIOs," examines the important role health information management (HIM) professionals can play in the emerging domain of health information exchange (HIE). AHIMA's HIE Practice Council interviewed a number of HIM professionals that successfully transitioned into HIE. Skills needed to make a successful transition to HIE roles include data management, analytics and project management.

Read these articles and more in the August issue of the *Journal of AHIMA* or online at journal.ahima.org.

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About AHIMA
The American Health Information Management Association (AHIMA) represents more than 71,000 educated health information management and health informatics professionals in the United States and around the world. AHIMA is committed to promoting and advocating for high quality research, best practices and effective standards in health information and to actively contributing to the development and advancement of health information professionals worldwide. AHIMA's enduring goal is quality healthcare through quality information.
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