

A history of icd-9 and icd-10 essay



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Back in the 1700s, the first attempt at classifying diseases was made by a French physician, François Boissier de Sauvages de Lacroix, who wrote the first book on the subject “ Nosologia Methodica. ” Many different physicians followed up on his process, upgrading it to better reflect diseases as more were discovered. In 1853, at the first International Statistical Congress in Paris, it was agreed that there should be a uniform classification of diseases for the world to use. In 1855, the first standards for classification were introduced, and from that point on, there was an outline for how the coding process should work.

For the next 95 years, there were multiple revisions and changes to the code, but no universal agreement on the standards. Many countries developed their own coding system, although all used the bases that were already established in categorizing these diseases. In 1938, Canada introduced a proposal for the listing of causes of diseases. The Fifth International Congress adopted the ruling although there was no formal action taken on it. By 1944, there was a provisional list of diseases and Injuries, presented by the U.

S. and the United Kingdom. It wasn't until 1948, just after the creation of the World Health Organization (WHO), that there was a committee put together to establish one revision to represent all countries. The idea was to put together not only a classification of causes of death, but also classifications of illnesses and injuries. This became known as the Sixth Revision of the International Lists.

The committee created the “ Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death” from the data, which was in two volumes. By the time of the 7th revision, in 1955, the name International Classification of Diseases had been adopted. The 9th version of ICD came about in 1977. To date, it's the last version that every country adopted at the same time. Incorporated into it were many of the category extensions of diseases and maladies that several represented countries wanted for better clarity of what was occurring in their areas.

The next update for ICD was supposed to begin in 1985, following what had become a 10-year process for working on ICD codes, however, it was pushed back to 1989, and continuing delays kept it from coming out until 1995. ICD-9-CM, an abbreviation for the International Classification of Diseases, Ninth Revision, Clinical Modification, is an arrangement of classes or groups of diagnoses and procedures by systematic division. ICD-9-CM is based on the official version of the International Classification of Diseases, Ninth Revision (ICD-9), which is developed by the WHO in Geneva, Switzerland. The WHO assumed responsibility in 1948 for preparing and publishing the revisions to the ICD every 10 years.

The ICD classification system was designed to compile and present statistical data on morbidity, the rate or frequency of disease, and mortality, the rate or frequency of deaths. This form of classification was first used by hospitals to track, store, and retrieve statistical information. However, a more efficient basis for storage and retrieval of diagnostic data was needed. In 1950, the Veterans Administration and the U.

S. Public Health Service began independent studies using the ICD for hospital indexing purposes. By 1956, the American Hospital Association and the American Association of Medical Records Librarians, now the American Health Information Management Association, felt that the ICD form of classification provided an efficient and useful venue for indexing hospital records. In 1979, ICD-9-CM replaced earlier, less specific versions of the classification system.

The ICD-9-CM streamlined the other versions of ICD classification systems into a single classification system and was intended for use primarily in hospitals in the United States. The ICD-9-CM provides a more complete classification for morbidity data to be used for indexing and reviewing patient records and medical care. Within the United States, two agencies are responsible for the annual updates to the ICD-9-CM codes. The National Center for Health Statistics (NCHS) is responsible for maintaining the diagnostic codes in Volumes 1 and 2 of the ICD-9-CM. The Centers for Medicare and Medicaid Services (CMS) is responsible for maintaining the procedure codes in Volume 3 of the ICD-9-CM. Since the clinical modifications have been developed, ICD-9-CM has been used to code patient encounters throughout the U.

S. healthcare system. The Medicare Catastrophic Coverage Act of 1988 mandated the reporting of ICD-9-CM diagnostic codes on all claims submitted to the Medicare program. In subsequent years, private insurance companies required ICD-9-CM codes to be submitted.

ICD-9-CM provides a coding system that reflects the signs, symptoms, disorders, diseases, examinations, or other reasons for the services billed by a provider for payment, giving the payer a clear picture of the reason for the patient visit. ICD-9-CM is the key storyteller to the insurance companies, explaining what brought the patient into the office or facility (by use of a diagnostic code), as well as what services were provided by the facility (by use of a procedure code). Because coding plays such a critical role in reimbursement for services rendered, correct coding practices are essential. The International Classification of Diseases, Tenth Revision (ICD-10) was endorsed by the Forty-third World Health Assembly in 1989 and came into use in WHO member states in 1994. The classification is the latest in a series which has its origins in the 1850s.

The first edition, known as the International List of Causes of Death, was adopted by the International Statistical Institute in 1893. The WHO took over the responsibility for ICD at its creation in 1948 when the Sixth Revision, which included causes of morbidity for the first time, was published. The World Health Assembly adopted the WHO Nomenclature Regulations that stipulate use of ICD in its most current revision for mortality and morbidity statistics by all member states in 1967. ICD-9-CM has several problems. Foremost, it is out of date.

Because the classification is organized scientifically, each three-digit category can have only 10 subcategories. Most numbers in most categories have been assigned diagnoses. Medical science keeps making new discoveries, and there are no numbers to assign these diagnoses. Whereas

ICD-9-CM contains more than 17, 000 codes, ICD-10 contains more than 141, 000 codes and accommodates a host of new diagnoses and procedures.

In many ways, ICD-10-CM is quite similar to ICD-9-CM. The guidelines, conventions, and rules are very similar. The organization of the codes is very similar. Anyone who is qualified to code ICD-9-CM should be able to easily make the transition to coding ICD-10-CM. Many improvements have been made to coding in ICD-10-CM. For example, a single code can be found to report a disease and its current manifestation (i.

e. , type II diabetes with diabetic retinopathy). In fracture care, the code differentiates an encounter for an initial fracture; follow-up of fracture healing normally; follow-up with fracture in malunion or nonunion; or follow-up for late effects of a fracture. Likewise, the trimester is designated in obstetrical codes. While much has been said about the huge increase in the number of codes under ICD-10-CM, some of this growth is due to laterality.

While an ICD-9-CM code may identify a condition of, for example, the ovary, the parallel ICD-10-CM code identifies four codes: unspecified ovary, right ovary, left ovary, or bilateral condition of the ovaries. Computer science, combined with new, more detailed codes of ICD-10-CM, will allow for better analysis of disease patterns and treatment outcomes that can advance medical care. These same details will streamline claims submissions, since these details will make the initial claim much easier for payers to understand. The Department of Health and Human Services (HHS) has mandated the replacement of the ICD-9-CM code sets medical coders and billers in the United States use now to report health care diagnoses and

procedures with ICD-IO code sets, effective Oct. 1, 2013. Only a handful of countries, including the United States and Italy, have not adopted ICD-IO as their standard for reporting.

The change to ICD-IO-CM for diagnostic code reporting across all of health care ” and the implementation of ICD-IO-PCS (Procedural Coding System) for inpatient procedural reporting for hospitals and payers ” will be the most challenging transition since the inception of coding. The number of diagnostic codes under ICD-IO-CM will swell from 13, 500 to 69, 000. For inpatient procedures, the number jumps from 4, 000 codes to 71, 000 codes. ICD-IO codes will also improve claims processing and payment, and, through the use of health care technology that utilizes ICD-IO codes, assist health care practitioners in making treatment decisions by more precisely matching diagnoses and procedures to the appropriate code. In the long run, the patient will benefit and hopefully this will improve healthcare in the United States by making claims and reporting data more accurate. It will be a challenge for the healthcare system to adopt these new practices but it can be done.