ICD-10: Myth v. Fact

Myth: The number of codes used by physicians will increase from 18,445 to 141,752.

Fact: The number of codes used by a physician is dependent upon specialty and additional detail necessary for ICD-10. Every code will not be applicable to every physician.

Myth: More codes equal more complexity and difficulties in use.

Fact: Only the subsets relevant to a specialty's patient population will be used by physicians within that specialty.

Myth: The increase in the number of codes requires the coding of clinically irrelevant detail that is a coding and reporting burden.

Fact: The major cause for the increase in diagnosis codes is due to separate codes for left and right body parts and increased an increase in the number of codes required to stage treatment for injury. Both side of the body and stage of treatment are always well-documented and do not represent an additional coding or reporting burden.

Myth: Because there are isolated examples of codes that will be rarely used, the entire system is riddled with unnecessary detail.

Fact: Medicare only requires a narrow set of external cause codes dealing with medical interventions be used.

Myth: The new coding system was developed by bureaucrats and is not relevant to physicians

Fact: The US Centers for Disease Control Statistics (NCHS) spent 9 years accepting input from the clinical community in order to develop the system for the US. The input was received from private practitioners and physician specialty societies

Adopted from the article Misperceptions, Misinformation, and Misrepresentations: The ICD-10-CM/PCS Saga by Richard F. Averill, MS, and Rhonda Butler, CCS, CCS-P