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Health IT Trends

Coding system allows different EHRs to use common language

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Many pediatricians are breathing a sigh of relief now that implementation of *International Classification of Diseases*, 10th Revision (ICD-10) has been delayed until Oct. 1, 2015. Taking a breather is absolutely justified. But it is in your practice's best interest to continue your transition plan and use the extra time to make sure you will be ready to implement ICD-10 when the time comes.

What might not be on your radar is the meaningful use program requirement to convert problem list information from ICD-9 to the Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT). SNOMED CT is a collection of medical terms that is systematically organized and computer processable.

This collection is far more comprehensive than many other coding systems and includes diagnoses, clinical findings, symptoms, procedures, body structures, etiologies, pharmaceuticals, devices and more.

Why SNOMED now?

In an effort to standardize the way electronic health records (EHRs) store information, SNOMED acts as a translator to allow different systems to use a common language. As we move toward exchange of information across systems and platforms, it is critical that we are all speaking the same language.

If EHRs are to provide improved clinical decision support, then it is essential that the support is built on the same framework. This will facilitate implementation and sharing of standard clinical pathways and care plans with the ultimate goal of improving patient care. In addition, having a common language helps researchers collect patient data for more accurate comparisons and makes patient registries include more specific information.

Stage 2 of the meaningful use program to qualify for incentive payments to implement EHRs requires systems to store and exchange information for certain items (e.g., problem list, family history and smoking status) as structured SNOMED CT codes. Unfortunately, there is no direct one-to-one map from ICD-9 to SNOMED. If you are using an EHR, you should ask your vendor the following questions:

- Will you have to completely remap your problem list?
- If so, what will that look like?
- Will the vendor provide possible mappings for you or will you have to look them up?
- What does the SNOMED search capability look like to a user?
- Will you have to re-collect family history information from your patients?

If you are not using an EHR, you may be expected to submit information (e.g., to patient registries) that includes SNOMED codes or you may receive information from other entities that includes SNOMED codes. All physicians should start to familiarize themselves with the coding terminology.

While this may seem like a foreign language, SNOMED CT begins to set the stage for better capture and exchange of clinical information about our patients. It is important to get this coding correct in patient charts. Remember, patients have access to this information through patient portals and will be able to download and transmit it to other clinical entities without asking us to verify the information before it is shared. Some health information exchanges move data on a regular basis without a practice verifying the accuracy of charts.

The time has come for us to review a chart for accuracy every time we touch it. Information is powerful, but only if it is accurate.

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