SNOMED CT vs ICD-10-CM

Clinical documentation vs billing — and how they map

Objective: Know when to use SNOMED CT vs ICD-10-CM, and how they relate.

At a glance

Dimension	SNOMED CT	ICD-10-CM
Purpose	Clinical documentation (problem list)	Billing, statistics, reporting
Structure	Poly-hierarchy + relationships, ~350k concepts	Mono-hierarchy, chapters, ~70k codes
Granularity	Very fine; pre/post-coordination	Coarser; built for reimbursement
Identifier	Numeric concept id (44054006)	Alphanumeric (E11.9)
Steward	SNOMED International	WHO (ICD-10) · NCHS + CMS (CM)

Mapping

- Use the official SNOMED CT ’ ICD-10-CM map — relationships are many-to-one or one-to-many, not 1:1.
- A map target can be exact, or carry a rule/choice (laterality, episode, combination).
- Never reverse-map ICD ’ SNOMED blindly; ICD loses clinical detail SNOMED keeps.

Which system for what

- Document the problem list in SNOMED CT · bill in ICD-10-CM.
- Procedures: CPT/HCPCS (outpatient) or ICD-10-PCS (inpatient) — not ICD-10-CM.
- Labs/observations = LOINC · medications = RxNorm.