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The International Classif cation of Diseases (ICD) is the standard diagnostic tool for clinical, health management, and research purposes, put forth by the World Health Organization. Currently in its 10th version, ICD-11 is expected to release in 2017. Researchers use ICD codes to identify participants for clinical studies and to track healthcare utilization rates, among a variety of other purposes (e.g. to study access, quality, costs, and effectiveness of care, patient comorbidities, incidence of complications, morbidity, and mortality) (O'Malley et al., 2005). Clearly, code accuracy is paramount and existing priorities include assessing diagnostic congruence of ICD codes and medical records (De Coster et al., 2006). From the emerging evidence, we see that at least two ICD codes are needed

ICD codes accurately report the *exact* health record diagnosis, and in many cases, disorders that were not part of their most responsible diagnosis or contributing comorbidities were attributed to patients in administrative data. Less than 50% of ICD codes exactly matched the most responsible primary diagnosis and only 7% of cases matched for affective disorders. F   n   diagnoses (53% according to ICD co

also evident when examining comorb _   high healthcare utilization sł

codes, given their propensity to falsely attribute disorders. A clinical diagnosis or the use of a validated diagnostic tool would more appropriately measure the burden of disease in this cohort.

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