



## HIT Standards Committee Transitional Vocabulary Task Force Final Transcript November 4, 2015

### Presentation

#### Operator

All lines are now bridged.

#### Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Transitional Vocabulary Task Force. This is a public call and there will be time for public comment at the end of today's call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Floyd Eisenberg?

#### Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Present.

#### Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Floyd. Chris Chute?

#### Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine

Present.

#### Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Chris. Debbie Krauss is not able to join. Gay Dolin?

#### Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

Present.

#### Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Gay.

**Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.**

Hey.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Joseph Jentzsch? Marjorie Rallins? Nancy Orvis? And Rob McClure?

**Robert McClure, MD – Owner/President - MD Partners, Inc.**

Present.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Rob. And from ONC do we have Julia Skapik on the line?

**Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology**

I'm here.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Julia. Okay, with that I'll turn it over to you Floyd.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay. So thank you all for joining and just...are you displaying the agenda or the slides yet?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yup, and it looks like Joseph just joined.

(Indiscernible)

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay, ah, there it is; thank you. Welcome. So thank you. What I want to do is we'll first go through the workgroup charge again and a short recap of what we discussed last week and then get into discussion on some of the transitional vocabularies. So if we can move to...I'm not sure I'm seeing what you're displaying so I'll just...okay.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

I see the charge.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So we're...the charge, here we go. Thank you, I got it. So the main question is should transitional vocabularies be eliminated as alternatives in reporting for federal quality measure programs using EHR-captured clinical data elements and if so, which ones? Secondly we need to understand the impact of retaining the transitional vocabularies on reliability and validity of the measures and also the costs and implications to the vendors and providers to implement compared with what we have currently and vocabulary alternatives.

So rather than go through all of these assumptions, why don't we move to the next slide, which is a bit of what we discussed last week and did discuss that a specific class of information should basically have one vocabulary. And we might want to recommend as our discussion went last week, that where there are two vocabularies that the model might require some adjustment. The example we can dis...had discussed would be diagnosis versus condition where diagnosis may be more of a claims-based way of expressing what's going on with the patient versus problem or condition which is more of a clinical method. There are implications for that and we want to discuss that.

And, well, we'll see what slide 4 includes, but on slide 4 we will discuss what was recommended, and we can just go right to that, for each of the concepts, what was recommended back in 2011 for the preferred terminology in the transitional vocabularies. So this table comes from the CMS measures blueprint and indicates for folks creating measures, that's...the blueprint is there to guide folks who are creating measures and indicating the preferred terminology and the transitional vocabularies that were accepted.

So in this particular task force what we've been asked to look at is, if we just take the first example, condition/diagnosis/problem then do we continue with ICD-9 or ICD-10? And so I...and for encounter, what to use there for intervention, procedure there's...the next slide goes on to additional elements, but we can start with these. And this was mainly to...for us to discuss the implications for moving forward. So, does anyone have something to add to kind of...what I was trying to do is give a background on what we discussed last time. Is there something I might have missed?

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

That was pretty good, Floyd.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC.**

Okay; thank you. So a couple of things that we do want to know; we discussed the fact that there are...what exists in records may need to be mapped to some of these terminologies, and I think we discussed the risks of potentially changing meaning due to mapping. There was an interesting discussion of measure developers yesterday in a different meeting asking questions about if there was a change, what would be the impact on the meaning of the measure if the measure identified its denominator and validated its effectiveness using diagnosis, changing to...say that uses ICD-9 or 10, what would be the impact on the validity of the measure if we move to SNOMED? And does that require further evaluation of measures if we did that?

So, let me ask the group that question. If we do change...recommend removing terminologies, what evaluation do you think needs to be made to evalu...to determine measure validity? Comments?

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Well, that's a hard question...this is Rob.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

I know.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

But...so for me to even think about that I gotta talk through our current state and so, because I know what we want here is practical solutions. And so first off, actually don't know if every measure that is

currently a part of Meaningful Use started as a chart abstraction measure, but I'd bet the vast majority, if not all of them. And the...when we started the process of transitioning to electronic quality measures, there was I'll say a hope that that process would maintain fidelity in comparison to how the data that would have been generated in a chart abstraction process with what would happen using electronic quality measures.

And then, and this is an area that I don't have a tremendous amount of kind of experience and knowledge but, you know in those chart abstraction measures, I think there was obviously a lot of dependency on billing codes and...which are the primary, you know primarily our transitional vocabularies and as well as, I th...you know some other data abstraction information. And so I think one of the things that I haven't heard officially said, but there's no question that the process has indicated that people have essentially acknowledged that in that transition to electronic quality measures there's...the fidelity is under question as to comparison of rates before and after, even on the same data, let alone, you know the same hospital with changes in process you know, both how patients are treated and the data collection using electronic means.

So I think something that we need to keep in mind, and there are a lot of things to keep in mind, but one of them is this idea that the use of tran...of what we're calling transitional vocabularies, again mostly billing, is in some way a link to the processes that were in place with quality assessment when it was based on looking at billing data and chart abstraction. And so I'll stop there just with that one piece because I think we need to just kind of decide what are the pieces of information that we're going to decide are important in order to make this decision. And so that one is, is there an important element with regards to comparability to measure rates and data analysis before eCQMs and after eCQMs?

And then I'll say one other piece and then I've got others, but, and that is that the kind of it's not on the same plane in terms of analysis but the point of what data is captured, right? So how, you know and really I like to use the word encoded, so how is data encoded in the course of clinical care and the demands on an organization and on the individual practitioners in requiring through all of the different demands on them for more than one way to encode data? So the fact, I believe is that we're still in an environment where billing codes are the way that we ge...you know, that practitioners get paid.

And so if we're going to do quality assessment using different codes, then...and we've heard this and I think this is a part of our charge to decide, that if we want...particularly if we want people to think about encoding in a way that isn't focused on billing codes, I'll say I guess we are obviously in the midst of transitioning to an environment where we won't be paying as much based on specific acts and more on quality. But if we're asking people to encode in more than one way, then we have an obligation to provide I want to say definitive maps between the two. So that's another thing I think that we need to think about and have a firm opinion on because it may provide a, you know support for our final decision. So I'll say those two things.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Rob, thank...

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

This is Chris...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Thanks, Chris.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Go ahead.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Go ahead.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Yeah, Chris Chute; you asked, you know about the validity of these measures and that's always a loaded question, I mean what is truth? I think it's indisputable that if we migrate from effectively billing codes to clinically generated codes there will be, how do we phrase this, inconsistency over time longitudinally but that's separate from the question of validity.

Many of us who have used billing codes for secondary purposes, be it decision support, be it epidemiologic analysis, be it, you know, other kinds of analytics, recognize that billing codes are, how do we phrase this, distorted from the clinical picture for a variety of reasons, not all of which are fraud and abuse. Quite frankly, if a code is not pertinent to a DRG, if a diagnostic concept simply doesn't factor into the calculation, it's ignored and this is perfectly legitimate, but it does distort the shape, flavor and, if you will, the underlying validity of the data from a clinical perspective.

So I think there's no doubt that if you were to use these primary vocabulary, SNOMED as opposed to the alternative vocabularies, the quality metrics and the answers that we would be getting would be measurable different from what had been previously generated. The question you asked though was validity and it's...that's a, you know, as I say, an abstract philosophical concept but I submit that data that is coded for clinical purposes and is comprehensive and complete clinically is going to actually have higher validity than data that is generated for reimbursement purposes.

**Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology**

And this is Julia Skapik; I thought I'd just answer Rob's questions. My knowledge is that...of the published Stage 2 measures that all of them were retooled from previous claims measures and so far the evidence we have on the validity of a claims measure in electronic format is that it generally does not perform identically and CMS has even publically stated that users shouldn't expect the performance of an electronic version of a claims measure to be identical to the electron...the present claims measure itself.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So thank you, I think that's all very good information and I guess what that leads me to is, we would expect that using the primary vocabularies we might have different results and, as Chris has indicated, that it may be more useful results. I guess the other question that actually came up from a discussion in another venue yesterday, and Rob, I think you were on that call; there were two questions. One is can we rely on the clinicians to document effectively using SNOMED? Do they understand it well enough to document so that we get reliable data, an...are we there yet? And one other question came up is can SNOMED express everything we need to be able to express? I'm not voicing an opinion; I'm just stating those two questions that came up so I'm interested in the responses.

**Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.**

Hi, this is Gay and those are actually, I think, some really good points. And, you know, first of all, I don't think that clinicians should be expected to be...to code based on SNOMED, they're going to code on the term that they...two, they're not going to be looking up codes and we shouldn't make it their responsibility to judge whether it's a correct SNOMED code or not.

Secondly, the...your second part of the question which I think was how to use granularity and close coordination required in SNOMED to get to the full clinical expression that you need. And while I certainly support that and would love...that, I don't think that the reality in EHRs is that they're there yet. Most EHRs can't say more than one code from each code system and so, that's, you know absolutely what we find from the looking at value from an IMO perspective is that it simply can't save more than one code per code system. So I think that's going to be an issue and it could be necessary in a way that, you know, ICDs for example, may still be required at least from the use perspective and with some translation going on between...translation or mapping going on between the codes that are saved if SNOMED is then to be sent.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

Umm...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Other comments on those questions?

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

Yeah, this is Nancy Orvis from DoD, I mean umm, I think it's real critical, I can't see our providers doing this for a couple of years; it's just very diffic...we're in the middle of we're going to be implementing a new EHR and as the previous commenter mentioned, the state of the EHR is what we're looking at for whether that can support it, not whether our providers have learned SNOMED CT in the next 2 or 3 years to do this. And particularly on thinking of what quality measures that generate out of conditions or the conditions list, problem list, condition list umm, code and I think the other question is a lot of these measures are in inpatient so, that would also trigger off of admitting and discharge diagnoses and intermediate diagnoses and so on and so forth.

It's, I think it's real critical to think what, and as someone said, if we don't un...have our providers understand it, where are organizations going to get the people who do understand what the correct mapping is? Is this again going to the medical abstractors or is this going to the EHR vendors to do the right mappings? Or is there a whole staff of informatics that each organization is going to have...informaticists?

If we can help fra...I think part of the discussion and part of the pushback or problem on this is trying to figure out which roles in a healthcare provider organization are going to do this work and check the quality of these eMeasures, you know that the numerators and denominators are correct. And I think if we could help frame that discussion it's not terrible to say there need to be new roles in an organization but we need to be, I think it would be help in order do eMeasures, where do you need to focus your resource...your staffing resources? On the providers themselves or on particular informaticists that are in between? So those are my comments on this.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Thank you Nancy.

**Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology**

And Rob, can I ask a point of clarification of Rob's comment from earlier? Rob, I interpreted your comment to say that we needed to provide a gold standard for mapping so that every place didn't have to pour resources into informaticists, etcetera, especially since some sites aren't expected to have those kinds of resources. Was I misinterpreting that or is that something...

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

No, you weren't, you weren't misinterpreting the...that's what I was alluding to. I think, you know, this is...the way I think to get to a reasonable end game here is to kind of focus in on certain things and so one of them is, what are our basic tenants and then kind of deal with some of the practical implications of that.

For me personally, I've continued to believe that the way forward with this implementation of electronic health records and the value that that brings to our whole healthcare community is that at its center, it needs to support encoding, and I talk about this frequently so I'll just say it now and then I'll be done. So all the information you put in an electronic health records doesn't have to be encoded and what you encode now may not, or what you don't encode now, doesn't mean you won't be encoding that in the future. So those two things, I think, are basic truths. It's a complex landscape but that's the way I see it.

That means that when we do expect encoding, we should one, it should always be focused on improving patient care. I mean there are a few edge cases that you could potentially argue for, but if we're not fighting for better encoding of data to improve patient care, then I think we're on the wrong side of the battle. And then in doing that, that's why I think the preferred terminologies were selected, because they are intended to be discrete, detailed pieces of information that are presumably what's important in the context of encoding for clinical care.

The...when we looked at, you know for decades I want to say, everyone thought about this, we've always assumed that if we were in a perfect system when we do that work of encoding, the expectation would be that any secondary effects, i.e. billing, would be done based on the encoded data, right? Again, with some edge case stuff going on which gets, I think, to Nancy's point and also is the kind of...the impetus for what I said which is, if that's the truth, if that's really where we want to start from then I think we do have an obligation to provide clear guidance, perhaps even direct maps for those areas where we expect encoding and also expect a different thing to be submitted for billing. And if we did that then I think we can be a little bit more expectant with regards to vendors and clinicians.

Remember, and I know Nancy and this is true, we...when we think about this, a lot of times I think we think about hospital and inpatient environments, but the impact of this where it's most dramatic is outside of that, in practices. And so we have to make sure that anything we do, including suggestions, which I think is a good one, of additional roles can be supported in a non-institutional environment; whether that be through, you know accountable care organization type work or, you know, the community physicians are going to be forced into two paths and we have to come up with a solution where both those paths, there's ready availability of the resources necessary for them to not have to take on the entire burden. I mean, it's a huge burden to get them to encode...

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

Yes, I agree.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

...and that's all they should do is do one encoding and then everything else should flow based on the work that we do, because we're expecting this activity to happen. So I think we do have that burden.

And I'll finish by saying, that whole discussion has this idea that the preferred terminology is the base terminology that's encoded. But I think part of the reason that we're even having this task force meet and dealing with this problem is that the fact is the transitional vocabularies are the things that are encoded right now. And so to some degree, everything I just said is backwards because we're thinking, okay, if we can get people to use SNOMED, then we can get them to ICD-9, ICD-10...well, ICD-10 and CPT and things like that.

When point of fact, you know if you have that conversation, anyone listening to this call right now is going to go, well that's crazy because I'm not doing SNOMED, I'm doing CPT, I am doing ICD-10, I just put a lot of money into getting into ICD-10 and you want SNOMED. So I have to go the other way. And so we have to deal with that reality, even though when I think about this I...what I wanted is I wanted people to encode to support clinical care which is discrete data and I want to get them ICD-10 for free. But they're...the place that all of the folks that we're talking to is the exact opposite; they're encoding right now in ICD-10 and they need to derive SNOMED CT; so we have that problem to face, too.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So thank you, Rob, and I think what you just addressed is kind of the crux of the matter and I want to mention, we have a number of things on this list, we've been mainly talking about conditions and diagnoses, but I think there...that's one of the thorniest issues. But what you just mentioned is a big issue that the primary doc...primarily they are documenting, encoding in ICD-10 now so I guess the question is, is there a path forward and how do we handle that? I don't think we're going to expect anyone encoding in ICD-9 going forward, is that fair to say?

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Yes it is; put me in the queue if you would, Floyd.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Sure, why don't you go ahead next, Chris.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Okay, thank you. I agree with a lot of what's just been said by Rob but I think I have a slightly different emphasis. The reality is, as long as the alternative vocabulary exists and as long as it's required by HIPAA for billing; that is the terminology that will be used for coding, period. There will never be a migration to SNOMED as long as the alternative is in place. Now the implication of going to SNOMED is non-trivial. Many speakers have said incorrectly that it would be difficult for clinicians, if not impossible or unreasonable for clinicians to code directly into compositional SNOMED; it may require different kinds of informatics support, it may require a different kind of vendor support and so on.

I think the only way forward, personally oh, and let me add another caveat, as an academic whose looked very carefully at this whole question of mapping and indeed, in our work on ICD-11 the question of mapping to SNOMED and vice versa I think most scholars in the field recognize that maps are at the highest level fundamentally fake and that it is not practical or possible to map from ICD into SNOMED. You can publish a map, but the validity and completeness of that map is provably incomplete in virtually every circumstance.

Rob is quite correct that the information flow was intended to go from granular SNOMED into a more lumpy and classifying rubrics and categories of ICD; you cannot go the other way, so I think maps are not viable. I think the only way forward is to declare a date, and it can't be next week, that would give and have clarity around the fact that primary coding is to be done in SNOMED for clinical purposes, secondary use quality metrics, everything else and as Rob said, oh yes, the derivation of correct and adequate billing categories, if they're still needed, from the granular underlying data. That would incent providers to demand that their vendors support that kind of activity.

Right now there is no drive for vendors to support correct SNOMED coding, I mean, there's no market for it, there's no demand for it. The fact that it's a required code is mitigated by the fact that we have these alternative codes. We will always have these alternative codes unless we declare a date after which, you know the intention of primary coding and the clinical classification is now required and that the information would be derived.

I know many of us had felt that the burden cannot fall on clinicians, it is impractical and unscalable and whether the ultimate technology is, as many of us have posited, clinicians would use basic short phrases of English language to describe the problems and that they would be algorithmically mapped using natural language processing, using other kinds of techniques into the correct SNOMED coding. That would be a vendor challenge; its obvious small practices can't do that. I think it would be a boon to clinicians, they can say what they mean; it would be a boon to secondary data use in that you'd have granular, hopefully reasonably well coded SNOMED and it would satisfy the fiscal billing requirements because it is possible to go from SNOMED to ICD, it is simply not possible to go the other way around.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

So Chris, this is Marjorie; I just wanted to let you know that I just joined a few minutes.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Oh, hi; yeah, Floyd is chairing. Glad to have you Marjorie.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Thank you, Marjorie. So Chris, I think you summarized things quite well as far as to make this change really requires commitment and a date or it may not happen. So I guess that data can't be quick, I know that we heard from Nancy Orvis the challenge of moving to a new EHR and trying to make changes, that these things do not happen quickly. And as you and Rob have said, the mapping goes one way from SNOMED to the billing codes.

So from what we're seeing in this...as far as this task force, I think what I'm hearing is, we can't eliminate the transitional vocabularies at this point and our recommendation may be if that's the desire, a date

needs to be set. What do folks think about that and how far out does that date need to be to make it practical?

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

So this is Marjorie and again, I apologize for joining in on the tail end of this discussion and you know, when I heard sort of eliminate the transitional vocabularies, that could certainly be taken out of context because we're still...are we talking about the transitional vocabularies from the perspective of reporting clinical quality measure results?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Yes.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Or are we talking about, is that what...that's what we mean.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Yeah, so I stand corrected.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Okay.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Thank you for the addition.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Yeah, okay.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So is there a...

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

So this is Rob, I'll just jump in one quick...in that space there and kind of reiterate what Chris has said. And the idea of saying we're going to, you know, our interest is in reducing the use or eliminating the use, I think in this context we're talking about for quality measures, of these transitional vocabularies I think isolates the statement too much and I wonder, even if we were to stay focused on the use of terminology in the context of quality measures, were dangerous. Because what Chris said, and is really the center point and that is, everything that we've kind of built around this is based on the assumption that we encode detail and we can generate everything else from that.

And, you know as Chris said, I mean maybe he and I are just thinking of this too simplistically but I don't see another solution other than the one he's suggested which is, we need to create an environment where that's...where we start from there and then guarantee that in moving everyone to that place, that they get everything else for free. And so they get quality measurement, they get payment, right? I mean,

you know quality measurement right now is it's crazy to say this but it's a secondary issue, particularly quality measure...it's not quality; that's not a secondary issue for anybody...

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

So Rob, this is Mar...

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

...it's measurement of the quality.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

This is Marjorie but, I can understand what you're saying, but the original recommendations were developed from that context and is our charge to go outside of that? You know, that becomes a whole different issue if that's the case.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So, it's an interesting question and yes, our charge is measures, so I'm...as I'm listening, the...it was interesting, I think there was some, although maybe only in a few, that by requesting these ter...the more granular ability to document clinically and deriving the billing from that, by starting with quality measures that would be a way to kind of get a foot in the door. But what's happened is it hasn't worked that way.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Yeah.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

And I think what I'm hearing Rob and Chris say is, this needs to be an all clinical care needs to be documented using the appropriate terminologies and derive billing from that, and that's a big change. And I think Rob and Chris, am I paraphrasing correctly by saying, you're talking about that for all care, for all documentation.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

And all secondary uses of which quality is a high profile secondary use, but by far not the only one.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

And I think we need to think, well, our focus has been on measurement, there's a focus on improvement so it should...we should be addressing decision support...clinical decision support as well. So, right, so...

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

That's more in...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

...so those are uses, right.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

And I can go with that; this is Nancy. I think you're basically trying to turn the paradigm that we've been working on for 20 years to finally happen, that there's clinical coding first and then billing coding is derived from it. And so I'm going to throw out, you have three choices for dates, four years from now, three years from now, two; I don't think two is real feasible, but to say within four years you want to have everybody change the paradigm and switch to clinical coding first and billing derived from it. That's...

**Multiple speakers**

(Indiscernible)

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

...will come and payment will come.

**Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology**

And this is Julia, I just want to...

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Yeah, this is Chris again and I...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

All right, Julia first for a minute.

**Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology**

I have some agency context. So there are three major activities that CMS and ONC and HHS in general have been engaging in recently that really sort of happen at the crux between clinical care improvement, decision support and quality measurement. And one of those is that appropriate use criteria for clinical decision support, one of those is the MACRA and the MIPS legislation which requires providers both to engage in quality measurement and continuous practice improvement. And the other is the standards which have now been merged to incorporate both decision support and quality measurement at the same time. Those are three things moving forward we should expect to be driving some of these activities in a greater scale than just the quality measures.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

That's helpful, thank you. But I think it's important to put this into perspective; the transition from ICD-9 to ICD-10, for those that experienced it was inordinately painful and yet as somebody who knows ICD better than I really want to, that transformation was trivial compared to the magnitude and impact of the transformation we're actually proposing. To do primary clinical coding, to have vendors support, whether it's natural language processing to SNOMED coding engines or not, is astronomically more complex.

And if it took us what, 25 years to adopt ICD-10, which is literally what it did, albeit we were only really trying for maybe 7 or 8 of those years, I think three...two, three, four year timeframes are wildly optimistic. The reality is, even if we said 10 years, when we get to the ninth year, there'll be a delay because nobody will really take us seriously until the ninth year; pretty much what happened with ICD-10. I'm not in a position to make an appropriate timeframe recommendation but I do want to emphasize as much as I'm philosophically and academically committed to this notion of primary coding of clinical data for multiple secondary uses, including reimbursement and quality, I do not underestimate the complexity and challenge of this migration.

And the only question is whether, quite frankly, the government, ONC and other people are serious about a migration to primary clinical coding. If they are, then it will be hugely disruptive and make, as I said, the ICD-10 transition look like a picnic.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

So...and Chris, this is Marjorie, I agree that philosophically, like you I believe primary coding of clinical data with clinical vocabularies is a good thing. But also as I shared with you and Floyd, I had committed last week to sharing that I do know that one of the transition vocabularies, CPT has spent time anticipating this...and actually has developed an ontology around the reimbursement part, you know, their reimbursement structure so that it can be used for these very purposes that we're discussing. So we might have to think about these recommendations not necessarily in sort of wholesale of all of the...transitional vocabularies that were originally recommended, but maybe, you know some and not others; do you see what I'm saying? I think we need to think about that.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Interesting, so...and I have to agree that the potential for such a change is huge. Every time there's big change it's always bigger than the last one, but I do think I would agree that this is a major change and requires major commitment. So given Marjorie's statement, should we start taking a look at these concepts one by one and see, is there something that can be done sooner or do we continue to use the dual approach that we have today?

So how about if we...this was a wonderful discussion, I think it's given a lot of good information. So we focused quite a bit on this condition/diagnosis problem understanding that the one option is they need to be separated so you know what you're looking for but would ICD-9 still be reasonable to include as a transitional vocabulary, just starting with the first row?

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Well, so we ought to probably bring...Floyd, we ought to bring some people up to the same level that perhaps you and I and a couple of others who've been on some of the other calls...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Sure.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

...have been on. My understanding of kind of the crux of talking about ICD-9 in the context of including or not including it in a transitional plan is kind of two-fold. One is that understanding that there's existing data that is encoded in ICD-9 for, primarily because of the reason we just said which is, all data that was encoded was encoded for billing and ICD-9 was the billing environment; so certainly on all the

inpatient data there's a tremendous amount of patient data in ICD-9. And so number one and we'll get back to this. Number two, the expectation that there are hopefully very few, if any, organizations that are coding in ICD-9...ICD are still encoding in ICD-9; they're all encoding in ICD-10, that assumption, I think is a pretty valid assumption.

And so the real question is the use of ICD-9 as a "transitional vocabulary," you know can we be explicit about where we think that makes sense and the discussions that we've had to date are, you know based on what I just said, if you're going to be doing any kind of analysis of prior patient data, i.e. those quality measures or any other kind of thing that needs to look at historical patient...a) patient's historical information, you know are we, one, I think we'd all acknowledge, obviously that's going to be...and a lot of that data's going to be in ICD-9 or something that's easily translated to ICD-9.

And two, do we have any expectation that it's reasonable to make people map that old data to something new because otherwise if we think that's not reasonable, we have no recourse other than to say that ICD-9 data will always be...or ICD-9 codes will always be an important part of quality measurement where historical data back to when it makes sense that there'd be ICD-9s recorded, that that should be allowed.

And I think, you know me personally, that's the solution...we typically have...traditional vocabulary and context...the data exists encoded using ICD-9 and that I don't see that there's a good reason to force that data to be recoded for any reason that's, you know to support a quality measure. If there's another reason, so be it people can do it. But for quality measures I think it needs to be in there. I don't know that I would call it a transitional vocabulary, I'd call it a necessary vocabulary for data retrieval and where it's appropriate to use it...it should be allowed and...

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

So Rob, this is Marjorie. A more specific use case might be reporting on a HEDIS measure that requires a...

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

I think we would call these legacy vocabularies, not alternative or transitional.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Right, or an...right, it's really alternative data...trans...terminology and there's a number of obviously again these are mostly what we call EH measures, hospital measures that have...persist, you know I just, I can't remember the phrase that they use but basically forever look-back periods to show any evidence of a patient having a particular condition. And so in those cases, I think we can kind of put words around that and that's where we totally expect it.

Now, you know would you be using ICD-9 to describe encounters in that context? Eh, maybe but I don't know, I mean we could get nuanced there but quite honestly, I'm not sure that it's worth being that nuanced. I mean I have strong feelings about the quality measures and where we should be putting a lot of our effort and where we shouldn't be and I'm not sure that this is the place where we want to get down into the tiny nails.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay, so I did hear a couple of comments there that are helpful; one is, it is...I like the I...comment of legacy because you're looking for data that exists in the past and avoiding mapping to something new just for the sake of removing an old voc...legacy vocabulary. But the question I have is, from our prior discussion on this call, are these really transitional vocabularies? Are these alternate vocabularies? Because unless we decide...unless there's a decision that at some future date there is going to be a transition, are they transitional at all or are they just umm, additional vocabularies that can be used and we know will be?

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Yeah, this is Chris. My answer to that question is they're clearly alternate vocabularies until such a time as named when they will be, you know the primary vocabularies will be the only vocabularies accepted. And this...I really think it gets into the fundamental question of whether this task force should be so bold, and I don't presume to know the answer; but whether this task force should be so bold as to suggest that really this whole transitional vocabulary problem centers around whether or not we are serious about ever migrating to a primary clinical coding world and all the implications that go with this.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

And that's a great question.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

This is Marjorie; I agree with you Chris, I think we have to decide that. But I do think that it's...there's probably a lot of complexities that we are not currently seeing at the moment and proceeding in this manner is probably being bold without having, you know the right glasses on. So, I mean just like we discussed sort of the legacy data or the historical issues with ICD-9, I mean would some of the other transitional vocabularies I always point to CPT, you know do we need to do that as well. I mean, and again I point to the other fact that CPT has modernized and maybe it shouldn't be considered a transitional vocabulary. Well when we get to that point, I might be, you know earlier in the discussion than we need to be, but I think that's something we need to think about as well.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

I want to chime in in support of Marjorie, I mean I think we do a lot of times focus on, and legacy is the perfect word for ICD-9 for example, and yet CPT is a primary coding system for the outpatient environment. And I think that, you know it does create this one complexity in that we've moved off of I&I and so to say ICD-9 is a legacy code is a pretty...coding system is a pretty straightforward kind of wrap it up in a bow kind of situation with the expectation that there will be no new codes in I&I and then we really are talking about this issue of whether I-10 is the right primary code system.

For CPT, it's covering both camps, right, and Marjorie's right, you know I'm aware of at least historically that there was a great interest in doing a more, you know, kind of supporting more discrete data potentially capture, I guess, or at least building CPT codes which are more classification oriented at times from, you know more granular data. And whether it's...

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Yeah...

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

...granular data using SNOMED or granular data using any other coding system; personally, I don't care. What I care is is that we focus on en...medical data and...coding.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Rob, we can't hear you.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Rob, you're breaking up, we can't hear you.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Sorry...can...hear...

**W**

You're still bad.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Sorry Rob...

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

No, sorry.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Yeah...okay.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Am I better now?

**W**

There you go.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yeah.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Yeah, I walked away; I had to walk in order to be able to think. Umm, now I just want to agree with to keep...we need to not throw CPT in a different bucket than ICD-9 because like ICD-9...component but more like ICD-10 and to some degree like SNOMED in the current environment. And so we need to be cautious about thinking about just code systems and I think what we need to think about is functionality, which is again...

**Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.**

Yeah I...

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

...let's focus on detailed data, do...deriving from that and if CPT could incorporate that...be a viable solution.

**Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.**

This is Gay; Rob, we're still mostly hearing every other word but I wanted to kind of echo the two points and also think about the other impactful things related to something like CPT and other things I probably don't even know about where there's al...for years been programs surrounding like allowed inpatient procedure only lists, for example. And, I mean that's one...that's just an example I can think of off the top of my head so whatever organization run, I mean CMS runs that but then we'd have to, you know, how is that...does it...is it affected...that affected by this or not? That's...and a lot of people have sa...both saved and lost a ton of money related to those inpatient only list procedures, so that's going to be very impactful.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So, this has been a very helpful discussion and I want to just do a time check; we have about half an hour left and we need to save at least 10 minutes at the end for public comment. So what...would it be reasonable now to kind of go through this list of what concepts that need to be addressed and based on the concept, identify the...we may want to consider whether we change but maybe keep the preferred terminology, but include the other as alternate or legacy. And perhaps ICD-9 may be the only legacy, from what I'm hearing so far, but is it reasonable to go through this list and see if we can have a discussion?

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

That's not unreasonable, Floyd, but I'm wondering whether we want to tackle the question, you know from the perspective of clinical coding versus reimbursement coding, which is really the dichotomy that we're dealing with.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Right.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

CPT may be an exception; I understand that; I'm actually reasonably familiar with CPT's effort and AMA's efforts to work with SNOMED on an underlying ontologic framework. But virtually every other layer of that table deals with the, are we dealing with clinical coding or are we dealing with reimbursement coding?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay. So how would you...are you talking about a higher level discussion about the...

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

I'm talking about whether or not we would presume to start with clinical coding is the goal as a premise. I think we have to make a decision about whether we want to do that or not because otherwise we're going to get wrapped up, as we go through this table line by line with...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Right.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

...that framework.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Good point and I think based on that, what is in our scope and is the scope to recommend full clinical coding or...for everything? One of the concerns I have is it sounds like we might want to recommend that that seems to be the preferred approach and should we be suggesting that further investigation is necessary in that area to see the implications and consider a timeline? Because I don't know that we have the time to really do that full investigation. Is that a reasonable approach to start with?

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

I certainly agree, we don't have the time or the scope to do the full investigation, so I think if we choose to address that point at all, you're correct the only way that we could do so is, you know more study is needed. But it's a core underpinning issue that we may choose to highlight.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Right. So...but I'm also, I think I'm hearing you suggest that the...rather than preferred terminology and transitional, perhaps consider that we want to indicate clinical terminology and reimbursement terminology and as our...

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Well I'd put it more generally, I'd say do we want generalized clinical coding or do we want use-case specific coding such as reimbursement.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Ah. Others have comment on that?

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

So I'd...this is Marjorie, I don't quite understand what we're trying to land on. So Chris you said use-case specific such as reimbursement versus clinical; is that how we would approach this?

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Well this was the first half hour of conversation, Marjorie and I'm sorry you weren't...

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

I'm sorry, then you don't have to repeat it.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

...able to join us, but the short version is, we all know that detailed clinical coding such as compositional SNOMED is going to give you much richer, more flexible and reusable data than fairly rigid, shallow category such as ICD; I mean, that's a first premise. And the point of the first half hour was, you know do we acknowledge that the intention was to go toward a granular clinical coding ideal, and I'll stress that word ideal, from which we could derive algorithmically other use case applications such as billing, such as quality, such as, and oh by the way, you know discovery ACO operations. I mean the list is very long and we all know it.

But the...I think the first half hour more or less acknowledged as long as we gave an opt-out for clinicians, vendors, other persons to do essentially fairly narrow, parochial reimbursement only coding, that all those other secondary uses would be poor cousins. And it is not...I think it is demonstrably true that it is not possible to get the same validity and quality of secondary use applications out of billing codes as it would be out of a primary code. And when do we pull the cord and say, yup, we're going to set a date and we're going to emphasize primary clinical coding.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Okay, thank you for that, that's very helpful.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Yeah, so Chris, I...from what you suggested, would we be better off indicating the terminologies here not by the ro...not across the rows but as far as identifying this clinical...general clinical coding or use case specific; is that kind of where you were headed?

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

That is where I was headed, yes.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Now if people disagree with that, I don't mean to ram it down people's throats, but that's my world view.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Any comments from the group on that?

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

This is Nancy. Chris, you want to have a stronger use case per se clinical...in order to promote clinical decision support beyond drug allergy type of thing that we need this kind of coding, and that would be one of the use cases for clinical coding?

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Well clinical decision support would be a strong use case for clinical coding. We all know that ICD performs abysmally, and I say this as Chair of ICD-11, performs abysmally for clinical decision support.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

Okay. I'm thinking, as she said before that tying that use case in order to like move EHR vendors to next generation more...that that use case is very strong and then tying the advancement of clinical quality measures to something like that I think would be a stronger...would be a stronger positive in terms of making the case for the reference terminologies.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

I wouldn't disagree with that; you have to understand I'm a card-carrying academic so I always think abstractly. For me that was implied along with 20 other fairly detailed use cases, but...or more, but I certainly agree clinical decision support is a very concrete and specific illustration of the kind of...potent secondary use one can get from granular clinical...primary granular clinical coding as opposed to trying to eek your way toward that from the reimbursement rubric side.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

Right. And the only reason I say that is pragmatically is physicians feel beleaguered by EHRs today anyway so that's a carrot that can come with the measures. I'm trying to figure out if we can tie those together; the stronger clinical coding here that will allow you more clinical decision support will then also benefit the quality measures.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Among many other things, yes.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

Among many other things, yes.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay, so that's a good direction so shall we start with the terminologies themselves and I think if we look at the, I mean, starting with SNOMED, I think it's fairly straightforward that this would...that would be a primary coding of clinical data. Any questions there or any comments? So, shall we move to LOINC; any comments on that one?

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

I just wanted to make the caveat that they're not going to finish the radiology proce...diagnostic procedures in there until January 2017, so it may not make a difference on this particular part of the recommendations. In other words, it's still maturing in those areas.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

As is SNOMED, by the way, I mean, none of them are fully mature.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

Okay.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

If we were to, you know have perfect maturity and completeness for every use case as the only criteria, we'd never use anything.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

Well I just, you know the one when you get to diagnostic procedures that everybody says lab and rad and all these interventional things, so.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Right and that's why when we do look at the individual use cases we may have a reason to say we defin...we need more of a reimbursement type, because it's not in the primary terminology.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

Primary terminology may not be mature in that area for full diagnostic procedures, for example.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Right. Okay. So when I look at...I'm going to do this by column because it seems like the preferred terminology column fits into the primary coding of clinical data with the caveat that neither one is complete everywhere. Is that a reasonable assumption to start with?

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Yes.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Yeah, this is Marjorie and again I apologize I can't see what you're looking at but was this part of the attachment in the e-mail that went out, the table that you're looking at, Floyd?

**Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology**

Yeah.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Yes, yes and it's basically the table, I forgot what page it was on, in the measures blueprint that indicates for each of six...

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Yes.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

...concepts, I can't count; yeah, six that...which is preferred and which is transitional. So as I look...

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Yes, you...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

...at the transitional column, right. We had in there ICD-9, which I think we've generally agreed or I've heard general consensus that that is more of a legacy code...type coding, but needed for identifying historical information. But that that is more on the reimbursement side of the world as opposed to primary clinical coding. Is that a reasonable comment?

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Yes.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay, so show...so we look at ICD-10, how would you classify that?

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Well I think it's a use case specific...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

...classification for...primarily for reimbursement.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

All right. So...

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Well it's used for reimbursement here and I think one of the things that we have to be careful and acknowledge is that the, well let's use ICD as the perfect example. I mean, ICD is...was designed, and Chris knows this better than anybody else, as a way of classifying things for analysis and so, you know and we...it would be foolish of us to not understand how important that is and so...

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

I'd actually quibble with the word analysis...

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Okay.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

...and I don't know how pedantic I should get here but ICD was primarily a mortality system and it was designed for tabulation, and I use that word advisedly, tabulation, to count things. That's why it's mutually exclusive and exhaustive, that's why it's a mono-hierarchy, I mean, there are lots of reasons here for its rather peculiar structure.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Right, right, no, that's a better word.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

I would not grace the intended use of ICD was analysis but simply...

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Only you can say that, Chris; I mean, no one else on this call gets to say that, but you can.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

I'm wondering about within the encounter that this is going to probably used for a lot of problem lists as an intern.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

This meaning?

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

ICD.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

ICD-10.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

ICD-10, yeah.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

As condition list.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Well, I mean, you know this is the practical reality, right, that we're...that Chris and I have been kind of pounding our fists about trying to, you know create a cliff to force change in.

**Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology**

Well and just a reminder, Rob that ONC requires transitions of care information for the problem list to be sent in SNOMED. So regardless of how it's coded, it needs to be sent only in SNOMED.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Right, well then...there's a good kick in the butt right for that cliff, that's right.

**Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology**

That doesn't mean they're not using it and saving it and everything else that means that for transition of care documents they're sending SNOMED.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

For those leaving and going to another place, they have to put it in SNOMED and they pay to get it mapped.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

And that's right, that's right.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Right and they're mapping potentially in the opposite direction than the intent was because with...

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

Yes, tell me about that. I have to find those tables, I have to figure that out...supervisor.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Yeah, which is potentially problematic for meaning at the other end and certainly would be problematic for understanding the results of the measure.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

Yes.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So we've addressed, I mean as far as condition/diagnosis/problem I think we've addressed the issue of ICD-10 being the alternate terminology that is used for reimbursement but is basically what...where things are documented today. What about encounter, as we look, there are a few options there; there's ICD-9 Procedures, ICD-10 PCS, CPT and HCPCS? I did hear discussion that CPT may have some primary coding clinical coding capabilities...

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Yeah, so this is Marjorie, I would say for the encounter the work that Rob mentioned earlier and that I've, you know that has advanced since he and I worked on that many years ago, has advanced and I would say for the case of encounters, that's something that CPT should be considered for primary coding. I will say that the HCPCS I think that was something that we struggled with years ago and people often wonder why that was recommended for encounters to begin with. And so I would look at that one as a...certainly as an alternate or a transition that can be considered. But so I'm sort of saying I think we need to think, you know as CPT being a little different and maybe we table encounters until I can come back and maybe present something on our next call with more detail to help us make that call.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

That's fine.

**Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology**

So why don't we move to the next one.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So we look at...we can table encounters, but we'll need to talk about CPT and HCPCS there and the ICDs.

**Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology**

Yes...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Diagnostic studies test names with the resultable test basically we had...they had indicated LOINC; we still have...and understanding that it doesn't include radiology today so we have HCPCS over on the right-hand side, any comments on that?

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

You're asking about a comment on HCPCS...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Yeah.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

...or LOINC as...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

No, HCPCS. Yeah, no LOINC I think we're okay except with Nancy's...

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Right.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

...comment that we can't state all radiology tests.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

But you've got...they've got basic...in there now, you know but they've got 7 other modalities to finish by next December. They are...

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Yeah, we need someone, I mean...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

...potentially to address appropriate use criteria, we need to be able to address radiology for sure.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Exactly.

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

Yeah.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

And I guess the real...the question you're asking, and unfortunately I can't answer that is what part of HCPCS was covering things that's diagnostic study test names that LOINC is taking over? And I'll be honest, I think if HCPCS says supplies and not this, so I don't know how it's...it's here and that's just me obviously being ignorant.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Yeah it's...this is Marjorie. When we drafted those recommendations I think we had the same question; I don't know why those were retained for this purpose.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Is there anybody on the call who understands why this makes sense to begin with? I hate to put it so bluntly, but what part of HCPCS...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

I...unsure.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

...covers diagnostic study test names?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

And I don't know the answer to that either, so...

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

I can take an action to go back to my coder and ask.

**Robert McClure, MD – Owner/President at MD Partners, Inc.**

Yeah. I think before we kind of dismiss it out of hand or whatever, we need to get an answer to that question.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay...

**Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense**

If anybody else wants...I have somebody that I can ask, I don't kn...and I can come back in a couple of days, but...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay. So...well, I think this is giving us some fodder for the next discussion but...so I should say, intervention and procedure have basically been merged together in how measures look at this and CDS. The difference was many had thought of procedures as primarily things that are billable and interventions as other things that a patient may do for themselves or you might do for the patient as the clinician, but it doesn't...it's not something that you would include in a bill. But that distinction didn't really work well so they all got merged into procedures and you'll notice all the terminologies are the same as well.

And communication was the issue of if I wanted to send a referral to another physician or ask a patient for information or inform them, how would I determine...how would I define that the communication...the type of communication that occurred? And that's a short description to try to describe what's sought here. So, it sounds like we can do some more investigation to be able to present at the next meeting; any other discussion about these? Okay, I think we've had some really good discussion here and we can pull together quite a bit of suggested recommendations that we can look at as a group.

And I just want to look at the next slide and let people see what our goals are here. We have another meeting on November 20, another on December 2 and we will be presenting some draft recommendations to the Standards Committee on December 16 and the final recommendations in January. So we have two more meetings to pull together some drafts and I think we're moving along nicely; been great discussion. Before we go to public comment, do folks have any other comments to suggest? Okay, Michelle, should we go to public comment then?

**Public Comment**

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Let's do it. Operator, can you please open the lines?

**Lonnie Moore – Virtual Meetings Specialist – Altarum Institute**

If you're listening via your computer speakers, you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. If you are on the telephone and would like to make a public comment, please press \*1 at this time. Thank you.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay, while we're waiting to see if there are any comments, I want to thank everyone for a really robust discussion and these are very important issues and moving to complete clinical documentation does have its challenges so I think this is a good way of bringing all that together in our discussions.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Floyd, it looks like we have no public comment.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Okay. Okay, I guess given that, we can adjourn for the day.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

All right, thank you so much Floyd. Thank you everyone for joining.

**Marjorie Rallins, DPM – Director, Quality Measure Specifications, Standards and Informatics – American Medical Association**

Thank you.

**Christopher Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**

Thank you.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Thank you.