



**HIT Standards Committee  
Transitional Vocabulary Task Force  
Transcript  
November 20, 2015**

**Presentation**

**Operator**

All lines are now bridged.

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – 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. Chris Chute?

**Christopher G. 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. 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. Deborah Krauss was not able to join. Gay Dolin? Joseph Jentzsch?

**Joseph L. Jentzsch – Principal Consultant – Kaiser Permanente**

Present.

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

Hi, Joseph. Marjorie Rallins?

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

Present.

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

Hi, Marjorie. 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.

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

Present.

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

Hi, Julia. Okay, with that I'm going to turn it over to you Chris.

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

Thank you very much, good morning everybody. This is the third meeting of our Workgroup and according to our agenda we are to review the Workgroup charge and plan so let's proceed to the next slide. The next slide, yes, that's the one.

As many of you know this is focusing on the utility of transitional vocabularies and what are the implementation impacts and potential futures that we would recommend regarding them, this is well known to you. Let's move to the next slide.

And that is residual questions from our previous discussions have been summarized here, specifically do we want to move towards a point of care clinical coding such as SNOMED that would be subsequently mapped, that is to say, do we want to collect granular clinical data at the source and encourage policies and opinions that would lead us into that direction over time.

And the second question is should there be a separate use case for reimbursement and other use case specific coding such as clinical coding.

The third question is, are encounters an exception and the CPT issues.

The fourth question is what about the HCPCS for diagnostic study names.

Finally, have we...any cases that are unrecognized and what changes might we envision to the guidance. This is in point of review again these are things that are known to you. Let's just for completeness go to the next slide which is on transitional vocabularies. These are the transitional vocabularies as they are established under Meaningful Use at present and then just again for completeness the dates and the work plan is the last slide.

I think what we can do is go back to the transitional vocabulary slide and I think...so previous slide, please. Thank you. And these are the issues that really deal with, as you see, concept, diagnosis, problem, encounter, diagnostic studies, intervention, procedure and communication.

Now one of our members had been charged with looking at some of the data that might be brought forward and Marjorie I believe that you had some materials that you were able to share with us.

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

Yeah those were...I think they're being distributed now Chris, thank you, this is Marjorie. One correction on the previous slide, I was to report on what was happening with CPT and their ontology model, I didn't have anything to present on HCPCS.

**Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**  
Fair enough, my error. So, I have your CPT slides.

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

Okay.

**Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**  
Is there any way that they can be shown on the broadcast screen here, the Adobe?

**Jaclyn Fontanella – Virtual Meetings Specialist – Altarum Institute**

Yes, yes, I'm going to pull them up right now.

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

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

I'll wait for that before I get started Chris.

**Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**  
Meanwhile are there any corrections or amendments to the agenda from any of our members? Hearing none and seeing the slides in front of us Marjorie why don't you proceed please?

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

Sure, so this is just a brief high-level overview of CPT and what has changed with CPT since we developed the original recommendations in 2011 and what I wanted to share with everyone was the ontology model that has been under development for quite some time and what we're showing here is a picture of the CPT ontology model which shows you, you know, the logical attributes, the route hierarchies, the additional meta-tags that are used with CPT and this really allows it to extend its use case beyond reimbursement, supports mapping and supports a lot of things that we're looking for in terminology today because the basis of our original recommendations were, could the vocabularies be used at the point of care, did they have some kind of logical model and that's why we had recommended the original set of recommendations were developed against that criteria.

So, this is a CPT ontology model if we could go onto the next slide I think there's a specific example. Yeah, so that's an example of a CPT code that, a specific one, magnetic resonance imaging any joint of lower extremity without contrast media. And this also shows you...this is an example using that logical model and it also shows you how CPT has dealt with things like negation.

So, you know, I didn't want to...I know we don't want to go into a lot of detail about the model. This is to demonstrate the work that CPT has done to really support interoperability integrating with, you know, vocabularies that can be used at the point of care or using CPT at the point of care as well.

And then there is one more slide that shows sort of, you know, the various...the modernization path that CPT has developed at...you know the AMA has done a lot of work and is looking to the future to insure that CPT sort of move along with the needs of healthcare, data needs, interoperability needs, etcetera. So, I'll stop there before we go into any more detail.

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

Thank you, comments on this presentation? I certainly have some but I'll let other speak first. Well then let me proceed. If we could go to the second slide in this presentation and you pointed out Marjorie for example that negation was accommodated and that contrast media is expressed with a "not" and a logical definition.

I'm trying to understand how...this is obviously a compositional expression and one of the concerns about SNOMED is that a lot of companies and organizations are not yet capable of representing any kind of compositional grammar or expression in their vended products that they still prefer fully pre-coordinated terms and concepts.

On this CPT ontology example, is this magnetic resonance imaging, does that logical definition roll up to a single pre-coordinated expression that has its own code or is this an expression that would be rendered in the record itself?

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

It's the first one; it rolls up to a single code. So, this is the actual breakdown itself which is the expression but it also from a hierarchical perspective rolls up to the higher one, the pre-coordinated one that you see.

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

Okay and at the risk of getting into too much detail, SNOMED also has a fairly, as you know, explicit description logic the EL++ and this seems to be more of an aggregation and simple negation logic. Is there formalism behind this logical definition or is it just all these things together except the thing that says “not?”

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

Yeah, I think there is a formalization, you know, Chris we would, you know, if we’d like to have others on the call to explain that at a different time we could. I think what’s important here is that CPT has integrated SNOMED with its vocabulary and actually is doing a lot of work with IHTSDO and I think that’s the, you know, important point that we’d like to make about, you know, the progress that they’ve made so far.

But the actual formalism itself I can’t speak to that in detail but I do know that there is some formalized, underlying formalization with this example.

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

Okay that’s quite helpful actually. Other comments?

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

Chris, this is Nancy Orvis, hi, Marjorie.

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

Hi.

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

The question I had, I had looked at AMA CPT data model about 5-6 years ago or 7 years ago, or no maybe 5, so is there more information about how they are trying to incorporate SNOMED? Is that what you said that CPT...

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

Yes, so, this...right and actually Nancy I actually worked on that original data model 5 or 6 years ago but... and they’ve really done a lot of work to extend it. So, what you see here is SNOMED is providing a lot of that logical model for the CPT ontology. So, that’s what you are looking at here. If we go to...yeah if you see some of the identification numbers, the concept IDs are SNOMED IDs. So, I think this really speaks well to how those two terminologies are, you know, integrating together and how the organizations themselves are working together in a partnership.

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

So, my second question related to that is, are some of these knit products that do coding, have they...how has that model been leveraged yet or has it been?

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

So are you saying...

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

Do you know?

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

Has the model itself been integrated into products and the AMA certainly has partnerships with it to, you know...so are you asking me what are the specific products?

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

Yeah.

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

Okay.

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

Because, I have my own license for my government's software but I haven't figure out a way...is there commercial products that have already incorporated that knowledge logic, you know, and I can...something like coding compliance editors or things like that. That's what I'm curious about, is that what they're trying to do? Is AMA trying to promote that?

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

I'm not quite understanding your question I guess. Is it trying to promote products or...

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

No, the incorporation of this model in the logic, you know, if the software can't leverage it then it doesn't do much good that's my...so I'm trying to figure out are you aware...is it being leveraged in products that's my simple question.

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

So, I would say yes and I would say that there...I wasn't using this forum to talk about products but I know that there are products that...there are vendors that are very interested in products that CPT develops and some of which incorporate this model and what I'd be happy to do is point you to people after this call I can get in touch with you if you'd like more information about that.

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

I would, thanks.

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

There is what we call a CPT developer's toolkit which, you know, is a product that uses the CPT data model and I can send you more information about that as well.

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

Great.

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

Sure.

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

Marjorie, this is Floyd...

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

This is Rob...

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

Okay.

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

Go ahead Floyd.

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

I heard Floyd first, so, yes.

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

Okay, so I guess just to follow on Nancy's question, so is the presumption that a clinician user would enter one code and that code therefore could be used for determining clinical relevance and also for billing or is that what the intent of this is? And do you know is it being used that way anywhere?

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

So, I think the answer is “yes” and “yes” Floyd. So, I think the use cases for this are versatile and you could use this...the intention is to use CPT for native clinical coding and to also generate your billing at the same time or if coding is done in SNOMED you could use this, you know, model to map to CPT for either clinical purposes or for reimbursement purposes as well.

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

Thank you.

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

Okay.

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

Rob?

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

Yeah, so Marjorie, do you...is the intention given the alignment with SNOMED that these...that CPT and SNOMED would be complimentary and that they would not overlap?

For example, I’m looking at the example that, you know, you were using here and looking in SNOMED the US edition it does actually seem like this example is not represented in SNOMED and so it’s a general idea where there is MRI of any joint in the lower extremity and then without contrast.

So, I’m wondering if the intent of CPT is to not explicitly not overlap SNOMED but to extend it in places that SNOMED does not have content or if there is a need for something, you know, there would be some process by which a decision would be made so, yes, actually that belongs in CPT and not in SNOMED or vice versa.

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

Yes, so I do think...I do know that SNOMED would not...they are complimentary in that SNOMED would not add, you know, a duplicate CPT concept into its vocabulary. At the same time, if we stick with our original sort of use case of clinical quality performance measures we’re looking at, for example, say we need a concept that doesn’t exist in order to represent a certain data element I know that the CPT model for adding new content has historically been reimbursement driven but at the same time that last slide shows you how they’re attempting to be able to add new content, not necessarily for reimbursement purposes, and I think there is a project that’s related to laboratory procedures to add that content in a more rapid fashion.

So, to go back to your original question I see the vocabularies a complimentary. Again, IHTSDO and AMA are working very closely together and I do remember years ago when SNOMED was still with CAP they agreed not to overlap their terminologies.

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

Yeah, so let me just add on. So, I mean, to some extent it seems to me that there is going to be overlap no matter what. Now this example, again, as I look, there is in SNOMED magnetic resonance imaging of any joint of the lower extremity, it's just what doesn't exist is explicitly stating "without contrast media."

So, what I wonder is that if CPT does not have magnetic resonance imaging any joint of lower extremity, you know, i.e., not including the contrast media part because that's in SNOMED but it would mean that CPT has a kind of spotty utilization of codes because it is missing spots where there is SNOMED.

And I'm wondering if you know that and if you do then there is this varied tight alignment, this makes me think of things and you just mentioned labs because of the...obviously with LOINC and so, you know, or in order to make any of these coding systems somewhat complete, in and of themselves, there is going to be concepts particularly, more general concepts, that are going exist in multiple code systems.

I think this is a really important issue because if it turns out that we things like CPT fill in information that's necessary in order to be able to do our primary goal, which is to represent clinical care, then I think we're considering the importance of maintaining the use of these "transitional" and I would suggest that's a bad phrase in our context, code system, but then it does raise this need to be able to show clearly when one code system is used how it directly aligns with another code system, i.e., mapping.

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

Right.

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

So, it is just this question of how...where there is overlap, you know, one are you saying that there is absolutely no overlap and I'm going to guess that you can't say that.

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

I can't...well, I can't say that. I would say there is...intentionally I don't think the code sets tend to overlap with one another. They do have different purposes however and we know that and hence that's why I believe AMA and CPT are working very closely together.

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

Yeah, let me...may I address that question somewhat...

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

I meant to say AMA and IHTSDO, sorry.

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

Yeah, thank you. And the analogy I want to bring forward is the partnership between IHTSDO and the World Health Organization in ICD-11 which I think is completely analogous and I think it gets at many of the issues we've been talking about specifically the notion of granular clinical coding of potential separate use cases of reimbursement and other secondary uses and of this question of overlap in relationships. And let me be explicit.

It turns out that IHTSDO and WHO, really since 2010, have been collaborating on a common ontology between the two coding systems. There was actually an AMIA panel on that topic this week that some of you may have seen on Monday I think it was, but nevertheless, the point is Rob to answer your question there is overlap between ICD-11 and SNOMED we don't consider that fatal.

The point of the common ontology is to have a semantic anchoring of the foundation component of ICD-11 that is to say the semantic network of ICD-11 and its derivatives of linearization which are the mutually exclusive and exhaustive coding systems.

The implication is that the pathway to take data that is coded in SNOMED in clinical records and through this common ontology and semantic backbone and the subsequent linearization into a mutually exclusive and exhaustive classification one could logically and algorithmically identify the appropriate ICD-11 rubric from underlying SNOMED coding and over time with additional clinical phenotype data from laboratory and medication and other kinds of sources.

So, although there is overlap, as Marjorie was saying with CPT, the use cases are different. I'm not deeply familiar with the CPT IHTSDO partnership but I could speculate that it's probably analogous to what is going on with WHO implying, at least in this case, that the data could be coded in a granular fashion in the patient record using SNOMED that from those granular encodings, and I think this example is not yet SNOMEDified. I happen to know from my discussions with Mark Musen and Bedirh Üstün and others that have been close to the CPT project that the intention is to align these atomic statements with SNOMED whether it has been done yet or not, I don't presume to know, but that's clearly the intention.

And you can sort of see where this would go that it's a clinical granular coding with SNOMED but you can aggregate those SNOMED concepts into a rolled up CPT rubric so to speak which in this case would be magnetic resonance imaging without contrast media and that's a billable code. It makes sense for reimbursement. It makes sense for all kinds of fiscal management and you can see the sort of duality of clinically coded data in something like SNOMED and its aggregation into something like CPT for a specific secondary use in this case fiscal accounting and reimbursement. That's a model that I think is going to continue to evolve and the whole question of whether they're an alternative terminology or a transitional terminology begins to take on a different complexion because they become complimentary and they serve different roles.

It does have an implication however that the primary clinical coding of patient data, that is what clinicians and healthcare organizations would care about, are things like SNOMED coding. The generation of CPT codes and the generation of ICD-11 codes would be premised upon the moral equivalent of grouper software just like today we take a pile of ICD codes and using groupers generate the corresponding DRGs, if you ratchet down a tier or a level it would be, as I say, the moral equivalent of groupers or an algorithmic process that would take the granularly encoded data in the patient record and generate these higher level intermediate categories like CPTs and ICDs from the granular information.

That sort of changes the complexion of whether these are transitional vocabularies or alternate vocabularies, they become, in a way, complimentary in that one is granular the other is aggregated and that in fact the aggregated data would be generated from the coded data or the granular data.

I don't know what implications that has for our little Task Force since I know that the people on this call are able to follow that argument, but I suspect that a lot of people in the community would...their heads would be spinning trying to understand what the heck I'm saying. So, before I prattle on further is there anybody on the phone that doesn't understand what I've been saying?

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

No, this is Marjorie, Chris and I think you stated that quite well. I think this really rolls up to...I know we have a small little group with a small little task but I really would argue that the task has larger implications and I think we have to really think about, you know, the practical implications of our final recommendations hence this is why we brought forward this model that we know that CPT is engaged in at the moment.

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

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

And Chris, this is Floyd with a comment. I think you stated it quite well and I agree with your concern that not everyone will necessarily be able to follow, but I wanted to also address, Marjorie indicated the use case of clinical quality measurement, although that is the focus of our Task Force I think we need to address that we're talking about clinical quality which includes decision support as well not just measurement and I believe that what we're talking about supports both but I just wanted to clarify that.

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

Thank you, good point Floyd. Other comments?

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

Chris...

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

So, this is Rob.

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

Go ahead, Rob.

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

Let me just...yeah, let me just a couple of add-on's to the points that I've made that I think we have just been discussing. So, one of them is, first I understood and agree with what has been said.

My concern I guess, the things...as we work our way towards some recommendations out of this group is two of them, one of them is that...well, I guess first I agree that I think it makes sense that there will be code systems that have different use cases that drive an ongoing need and that therefore there isn't one, you know, one ring to rule them all in a sense and we can't...I think we're coming to a conclusion where picking one coding system and saying that one coding system can meet all use cases may in fact be unlikely.

There is some value that we're kind of...clarifying that is somewhat technical in that for example SNOMED has some underlying capabilities that can tie to a lot of these other code systems that have their use case drivers and therefore there is an expectation that they will be used.

But there is an important caveat to that in that, and Chris you stated this, there is a tieback to let's say any reference terminology like SNOMED that allows for easy...I'm trying to avoid using the word "mapping" but easy transition from the code system that has a particular use case that you need to use for that say for example billing for CPT in particular in certain situations say reporting ICD-9 codes for other use cases, but having followed...having used those particular code systems that have this tieback to SNOMED that you're able to walk between those different use cases easier and that makes sense.

I would say that if we suggest that because of that the use of multiple code systems not only makes sense but is expected to persist than we're making that decision based on some assumptions, one this one, which is that those code systems that we suggest should continue to be used do in fact tie back to that, to SNOMED in this case to be specific.

And two, that it is clear that there are...where there is overlap that the mapping between those code systems is quite transparent.

Actually, I guess there is a third one because we haven't talked about it and it was kind of eluded to earlier and that is HCPCS. So, HCPCS I don't believe has a direct alignment with SNOMED, I might be wrong about that in terms of, you know, future tense, I don't believe it has one now, but it presents a slightly different problem based on some information that we saw passed around I think Nancy you had provided us and in that case the information that HCPCS was being used to represent or clear...well, I'll say, clear, I don't know that they are totally clear, but clear gaps when compared to SNOMED and actually potentially I think compared to CPT in that there are certain things that were important in the care of the patient examples being charges or essentially capture of the fact that the patient had been transported in an ambulance as a kind of procedure and I think there were some others that traditionally in the use case in the United States have been used, HCPCS has been used to represent and I don't think that information is also recorded other places or there is a way to record it in some of these other code systems.

So, I think we have this one core thing, which is that, I think, at least for myself I'm feeling more comfortable is that we would have ongoing expectations of use of these other code systems that...and where that makes there is a tie-in to SNOMED that's one of the reasons why we're comfortable.

Two, that where there is overlap there should be a clear mapping guidance so that it is easy for users who don't understand all the nuances to move between the different code systems.

And then three, identifying places where there is a different code system that isn't necessarily tied to SNOMED but it fills a gap.

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

Okay, I don't think most of us would disagree with those principles Rob, thank you for articulating them. Was there another speaker that was trying to come in?

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

This is Nancy, the only thing I wanted to add to that and Rob's was that in the particular example in the slide where we're talking about an MRI without contrast that's also going to...it is being addressed by LOINC this year with its work with the Radiology Society of North America where all those procedures are going to be assigned LOINC IDs as well.

So, not to muddy the waters but it just seems like the clarity of purpose of having laboratory and radiology procedures in LOINC test names or test result names, or however, we're going to need to differentiate that too. I mean, that's another...just throwing that in there.

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

Thank you and as many of you know LOINC does have a partnership with SNOMED albeit only on the laboratory side. What Nancy is referring to are clinical LOINC codes and to my knowledge that partnership with IHTSDO does not yet extend to clinical codes. It does raise interesting problems because we all know that CIMI and FHIR are tending to choose LOINC codes for their binding value sets and the whole notion of clinically granular coding we're back into the multiple coding systems as a challenge.

Let me, just for purposes of agenda setting, we're 40 minutes into the call and we have 50 minutes left, there was some discussion about whether we should actually endorse that there be a...that we allow multiple reporting systems not just data capture systems and with the expectation that the government would do the mapping or the algorithmic transformation on the principle that leaving it as an exercise to every reporter to come up with their own translation tables and their own reporting algorithms and transformation algorithms was a recipe for inconsistent data that's one thing I'll leave it out there for the moment.

The second thing, we need to reserve time, since this may be our last call before the December 10<sup>th</sup>, is that true, let me look at the timings of our meetings here, well we do have a December 2<sup>nd</sup> call so I was wrong. I was going to say we wanted to consider, you know, what are the conclusions of this Task Force for presentation on December 10<sup>th</sup> and I think we can begin to enumerate some overarching principles such as the original position of the HIT Standards Committee to have clarity and non-ambiguity with single reporting systems as a principle to be considered, the principle of clinical coding, granular coding underpinning these kinds of concepts and ideas, a recognition that alternative codes and transitional codes are not really equivalent things and that we're really, I think, moving into the direction of granular coding and aggregated purpose specific aggregation which is a different concept and it only begs what would be reported to different use cases.

I recognize that we're nested within the quality use case but I think, quite honestly, many of us would agree that quality is a framework for virtually all of clinical data aggregation and I think it should transcend simple quality metrics and consider quality healthcare but I digress.

Let me return then to this first question that I left dangling of the prospect of actually endorsing multiple or more than one reporting infrastructure with an expectation that whatever mapping or algorithmic transformation is needed could be done by a central authority rather than left as an exercise to every reporting organization. Comments on that question?

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

This is Floyd if I can start on the comments on that. I originally would have thought to support that so that the meaning that was obtained around the measures would be more consistent because there is one process for mapping, but in rethinking, since the data are used in individual institutions not just to report their findings but actually to improve performance that if we're talking about clinical coding it is needed for decision support and routine clinical process so in some regard every organization needs a way to be able to address clinical coding appropriately and so I think it is something that should be a requirement for all settings to be able to do their own mapping, although with the caveat that I'm not sure how we assure that it's correct.

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

What about the prospect of a federally supported service to which providers would submit that information and would fairly, you know, in a RESTful fashion fairly quick instantaneous fashion get the equivalent code? So, again, it's not left an exercise but could be a federal service either at NLM or ONC, or CMS, or somewhere to engage in that mapping rather than leaving it as an exercise.

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

What if we expanded that to say federally supported or federally approved so that perhaps private business could be part of that as well and I say that without any ties to a conflict of interest for business.

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

No, I think that's an improvement Floyd, I agree maybe it should be a federally published algorithm.

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

Right.

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

Or a service resource, you know, a Java application or something like that, but nevertheless, managed and distributed centrally. I have no problem if industry chooses to take it up, presumably it would be freeware, open source ware, whatever we want to call it, but the principle is that, you know, this notion of translation being left as an exercise could be addressed.

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

This is Marjorie, I agree with the centralized...with a centralized source for mapping. Who actually provides that mapping either federally or private I think that remains...we can leave that open but certainly we certainly need some consistency across, you know, users, right?

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

And I'd make a caveat, yes, thank you Marjorie, I'd make a caveat, this is Chris again, that a static published map like the GEMs map is probably not satisfactory for the kind of functioning that we're talking about it needs to be a more dynamic process which implies software and logic and it is really the publication of the mapping tables together work in concert with the exceptions rules, the logical rules for exception management which I think are really what the devil...the effective mapping of this information in concepts. Other comments?

**Joseph L. Jentzsch – Principal Consultant – Kaiser Permanente**

This is Joe Jentzsch...

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

This is Rob...

**Joseph L. Jentzsch – Principal Consultant – Kaiser Permanente**

I don't have the same background that you all have so I went to my colleagues at Kaiser to talk to them about it and they use the CMT to do all of their coding and that in turn generates all the different codes it is actually doing, as you're talking about the mappings, it is doing those mappings to SNOMED, CPT or whatever as the...so the clinician can actually, you know, enter the codes, enter their encounters where they think and then it generates those codes. It seems to me that this is the level that we need to be looking at not at the level after the fact. I think there are a lot of other organizations besides Kaiser that use tools just like the CMT.

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

Thank you, agreed, the only observation I'd make is...and I'm familiar with CMT I was part of its formation group in the 90s, in fact Simon Cohn and I had a grant that kicked CMT off, but nevertheless it is a Kaiser specific set of algorithms, an excellent set of algorithms and maybe it is a candidate for the national norm but it still I think highlights the fact that this notion of how we map from a collected source to reported source is still left as an exercise to the organization even though Kaiser is probably doing it better than most organizations I know, in fact, all organizations that I know. Other comments?

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

Yeah, so this is Rob, I think, you know, so we are...I think we do need to deal with some of the details and so the...back to our original question which is, are we suggesting that what is to be reported would be one code system or, you know, the code systems for which there are no other coverage and with the fact that other, you know, code systems like CPT, like ICD, like LOINC that might be either captured or used in a particular use case would, through this alignment with SNOMED, be able to come back and report only using SNOMED or are we suggesting that...and I'm not suggesting one or the other, I'm just trying to get things clear in my head.

Or are we suggesting that, no the expectation is that there would be multiple allowed code systems for reporting and it is just that because there is a defined way of moving between the code systems that exists that it is easy both for those who capture data and have to report it and those who need to build value sets in support of Meaningful Use or in support of decision support that they would be able to think about that primarily in one way, let's say SNOMED or CPT, or whatever, and then using this easily accessible service be able to generate the other expected reporting code system. So, which thing are we thinking that we would be tending to head towards?

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

Well, I won't presume to say what we are thinking but Floyd was very persuasive that, in his rethinking, it would be helpful for the organization to have in near real-time the corresponding mapping for its own internal quality applications and report metric applications and the like. So, I was persuaded by that comment and I'm moving away also from the concept of allowing multiple reporting classifications but only if there is a centrally distributed suite of software and resources that can support the dynamic mapping.

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

Right, so it sounds to me like that was kind of what I was understanding too that through the use of these other code systems that have, you know, a mapping to, again, let's say SNOMED, the expectation would be that SNOMED would be reported even though, you know, CPT or ICD might have been what was used to generate the captured information. I know I'm saying it that way because...certainly one that SNOMED would have been what they originally captured and then they generate ICD in order to...send ICD where there is a use case for that, CPT where there is a use case for that.

But then in terms of reporting for quality potentially in use for decision support they would have the SNOMED through a mapping or through a direct capture. So, that is what I'm hearing and I think that is, you know, a good reflection of what we really wish to happen. I just want to make sure that if we, in this transition period, where it is possible that someone might be capturing data natively using CPT or capturing data natively using ICD that what we're saying is that even in those cases we could still...reporting in SNOMED and if that is true and I'm beginning to sense that I want to believe that is true also and it does create some interesting demands on those who are creating those original value sets, you know, that for example are associated with a quality measure.

In order to make sure that the kind of information that is submitted, let's say that a CPT code like magnetic resonance imaging lower joint without contrast, is what was originally captured that would be in the value set might be something somewhat complicated because in this case there is no SNOMED code for this so it would be expression.

So, I think, you know, that's why I apologize for forcing us to think about all of the nuanced ramifications of where we're heading, but I just...I need to have that in my head and I want to understand what we're talking about.

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

That's an interesting...

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

And Rob...

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

Point.

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

Oh, I'm sorry.

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

Go ahead Floyd.

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

Yeah, Rob, I think it's an interesting point because if you...if the...specifically thinking of the appropriate use criteria where you will need to know whether or not contrast is used or intended and if SNOMED cannot give that level of detail then it's either in a value set or somewhere in a logic that someone is going to have to be able to express that. So, that does raise a really interesting point. I look for Chris and others to help us navigate that concern.

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

Well, thank you and my concern was really focusing on directionality here because when I was babbling about collecting coded data in a granular form and then using algorithmic maps and dynamic tools to aggregate them into things like ICD and CPT I was not thinking of the reverse case and Rob that's exactly the scenario that you articulated that in fact we have the reverse case the reality is today, most data is generated in ICD and CPT, which is backwards arguably, and that, you know, the reverse does not follow, it does not follow that we can take existing ICD codes and CPT codes and generate meaningful SNOMED concepts out of them. They would be just the same...they would have all the same biases and constraints that the existing ICD and CPT codes have in my opinion.

The ideal, I would state, is to have the data coded in SNOMED perhaps reported in SNOMED for quality purposes and metric purposes since we want the metrics to have the granularity and specificity to, you know, have nuanced numerators and denominators, which is not possible with ICD or CPT by design, but then allow the reuse of that data for other aggregated purposes, financial purposes, statistical purposes, mortality reporting purposes. I mean, we all know the laundry list of reuse of data, but I think the directionality here matters a lot and I'm hard pressed to see or to have enthusiasm to report a single SNOMED reporting environment in 2016 as the preferred reporting environment when in fact all of that data is generated from rather clunky deconstruction of ICD and CPT codes.

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

Chris, this is Marjorie, I agree, I would say that maybe that informs our recommendations then because practically speaking that is how many capture their data. And maybe what we're asking for is a reverse map. Is that what I'm hearing? I know that that's probably easier said than done, but that's kind of...maybe that's a companion recommendation as well.

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

I don't think a reverse map is theoretically possible that's my point. You can't get blood from a stone. I mean, ICD is a more aggregated concept, it lumps lots of things together by design, I say that as Chair of the ICD-11 Committee, you can't un-lump it without additional information from the record. I mean, there is...

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

Well, I think that is what is happening though, Chris...

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

I know that.

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

Yeah.

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

But it's a fool's errand.

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

And Chris, I think that the committee is free, this is Julia from ONC, is free to say the correct activity would be, you know, this following process but also to say that it's not possible to do that in 2016 we think it would be possible to do it in this timeframe if the thinking is that's really the most appropriate course of coding and then reporting.

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

Well, and so, this is Rob, I think, you know, part of what we're debating here in the practical near-term, and I understand, you know, Julia what you've said that perhaps our recommendations are really more someday in the future and not speaking to what we believe should be done now. I'm hoping that's not true because I think we need to give some guidance near-term.

And again I'm not proposing my opinion I'm just kind of reflecting what I'm hearing and how it seems to play out in my mind and that is...so for example, you know, with all due respect to what Chris is saying, I'm going to be really explicit about what Chris is saying in that one approach would be to say, given, again, given these new alternative code system approaches that are directly linked to SNOMED that if we were to say no, okay, knowing that, let's say expecting the use of these, which right now I don't believe are, you know, hardly used at all, but that a...again, an organization that is creating value sets in support of something like a quality measure, one possible solution would be to say "yes, they would be reporting in their value sets just SNOMED" but this reverse mapping, granted it is in a sense trying to get blood from a stone, but it's an expectation of understanding about the kinds of codes that are being used and to say, okay, we will take a generalization that is a direct derivative of, I have ICD in my mind which would be the most egregious example, there would be one code that actually is the official mapping.

And in essence what that means is that those who are creating value sets for these more...these use cases like, you know, quality measures, that someone who is collecting data using ICD-9 or sorry, ICD-11 in this case, that they would then have that code and it would be mapped to a SNOMED code as a, I don't know what the right phrase is, but as a general use case and that this code would be what gets into the value set and that is the only solution that I can imagine that would work where we would say, yes its appropriate for people to continue to...we're acknowledging, maybe that's the better way to say it, we're acknowledging that there would be some continued use of these use case specific code systems as data collection and where that occurs these would be the approved mapping from them to the only allowed reporting code system.

It seems to me that this is a potential solution. It may make some of our skin crawl but it is a workable solution if we chose to follow it. I don't know of another workable solution other than to do the alternative which is to say, we expect reporting to occur in multiple code systems.

**Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**  
I'm cueing up my tirade here Rob, but I'll let other people speak first. Other comments?

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

Yeah, Chris, this is Marjorie, again, I do appreciate that mapping from administrative code sets to clinical code sets, i.e., reverse mapping can be like getting blood from a stone but I think if you know...related to Rob's comment that's where people are, some, anyway, and I would recommend that we use one stone or one reverse mapping if we're going to do that just like mappings in the other direction need to be centralized so do the reverse maps.

**Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**  
Other comments? All right then I'll unleash my tirade.

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

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

Oh, go ahead.

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

I'm sorry you were asking for others. I guess one thing as I listened to all this really may depend on what information we're seeking. I think when we're talking about conditions that may make sense but when we're talking about things like procedures if we did attempt any reverse mapping we'd be talking about a post coordinated SNOMED statement as opposed to a code, at least as I'm thinking about it, maybe that's not appropriate, but that's where I'm concerned that what are we actually...how would we be able to do the blood from the stone without...to a single code when it really would take a pre-coordinated statement. I just don't know that I understand that.

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

Thank you and I actually agree that is a crucial technical reality that it is improbable that any of these codes, particularly CPT, which is, as we all know something of a run on sentence, would map cleanly to a single, you know, reverse mapped to a single SNOMED code. I think Marjorie's slides are actually quite indicative of the complexity of a logical definition needed to adequately define a CPT code.

So, here's my radical suggestion and tirade. I think pursuing the fallacy, and I use that term advisedly, of a reverse mapping from an administrative code to a clinical code is misleading and not of significant utility. It is exactly that it's a fallacy since the completeness of the information is absent by definition, this is what aggregated codes are all about, it's what classifications are all about, it's not a design flaw it's a feature, but declaring that we can recover the granular detail from a reverse map I think is a fallacy.

That has an implication and Rob asserted that the alternative was to continue transitional coding. I am actually suggesting something more honest than that, which means of course it's dead on arrival, but I think the honest view here is to say, look transitional codes are going to continue to be necessary because clinical data is not yet coded in granular form, most clinical systems today cannot accommodate appropriate SNOMED compositional expressions to even capture the granular clinical data and to assert otherwise is the height of denial and unreasonableness.

Therefore, we would make a recommendation, this is radical folks so write this down, we would make a recommendation that we proceed with a single classification or a single coding system in the immediate future, that this clinical system bows to the reality of SNOMED and, sorry, bows to the reality of ICD and CPT, that those would be the reporting systems and all the commensurate difficulties of being able to generate nuanced clinical quality metrics would persist, but I submit that's the reality today anyhow we're just being honest about it, but the caveat would be that the original intention of the Standards Committee to migrate toward clinically coded data that could support a plurality of secondary uses including quality metrics and reimbursement be preserved as a goal and be implemented as a determination that as of, you know, pick a date, and this cannot be soon, but at some specified time in the future there would be a transition to clinically coded data as the reported code system and that there would be no alternative codes or transitional codes permitted as of that date.

In other words, it would be a transition from our existing world of reimbursement and aggregated codes to a world of clinical codes. And we would give vendors and providers enough time to be able to implement that, and frankly it might take a decade, but I think persisting with the idea that we should report fallacious SNOMED codes derived from administrative codes is not a positive service to the country or the community, or the industry.

There, now that I'm fired from the committee anybody else want to talk?

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

So, Chris, just if I can interpret that, what we're really suggesting is that vendors or somebody out there needs to develop a mechanism to express clinical information in a post coordinated fashion to be able to meet the needs and we set a date in the future when that's necessary but be explicit about it and in the meantime perhaps these are alternate and/or complimentary vocabularies that we can use until that's ready. I'm just trying to re-express what you said in maybe...

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

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

Some simpler terms.

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

The radical part is that they would not be alternate or complimentary vocabularies, they would be the mandated reporting vocabularies and there would only be one.

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

Right.

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

And in the mandate we would put aside the charade that it is even possible to report in clinical SNOMED codes because it's not. And that the mandated...there be a single coding reporting system, it would be CPT and ICD until that transition day when we're actually capable of reporting SNOMED.

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

And...

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

But to report SNOMED at this time...

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

I'm sorry.

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

Is not useful.

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

And I think that makes sense except for a few instances such as encounters where there is an intent to identify a patient provider interaction that may not be represented in CPT today and it's not traditionally been billable but needs to be identified that it occurred and in those cases folks have been using SNOMED. I'm not exactly sure how they get implemented, but...so does...that might mean extending the existing vocabularies in order to accommodate those.

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

That might mean that. There will be edge cases and there will be, you know, short comings no doubt regardless of the decision that is made. It was my understanding that we actually had reason for encounter data in the Z-Axis of ICD-10 but I may be wrong.

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

So, this is Rob, I appreciate the discussion. This is exactly what I was trying to kind of generate because it's sort of the practical end game. So, a couple of comments on this. So, one, the...I think that, again, just to help me clarify, one of the...the main thing that we were being asked I think to consider was this current expectation of the use of these "transitional code systems" and therefore the expectation that there be multiple code systems used in these value sets to support particularly quality measures but other places and that it sounds like we're working towards perhaps saying "no that this isn't necessarily a good solution" and part of that is a derivative of the fact that we know where we are now and therefore sometimes it might be CPT, sometimes it might be ICD and that those single code systems would be the things that would show up in these value sets and multiple sets is kind of what I've been hearing.

And then the other is that, you know, a large part of the reason why we're pushing...that we're accepting that reality is that there isn't a way to exchange a reference code system like SNOMED in part because one, the maps still don't exist, I mean, these things that we're talking about are based on our view of a new version of CPT which I think is still being rolled out and is, I think, likely to not be currently used and in many places we're talking about ICD-11 when we've just gotten ICD-10 and so the ability to do this with ICD-10 I think is under some question.

But I do want to point out another element to just...not cloud the picture, but it's important to know, I was involved in work that was commissioned by the IHTSDO to look at how one could represent an exchange SNOMED expression and they do have a proposal to do that it's through a method where expressions, called an expression library, and it would be possible to generate identifiers for expressions, those identifiers, those expressions wouldn't represent IHTSDO, the real SNOMED codes, but it still would support the ability to exchange complex ideas with a single identifier.

So, I think there are potentially some solutions that in fact wouldn't even require the IHTSDO to support this, it could be potentially done even inside the United States, I know this for a fact because I helped design the system.

So, there are actually and I hate to kind of take us hard left into a side approach as, you know, our final recommendation, but I can tell you that if we wanted to support the ability of people to use CPT, ICD and other, you know, non-referenced code systems but yet report using SNOMED if an entity was responsible for determining what the expressions were that represented all of those codes as, you know, exactly like we're looking at CPT doing now, exactly like what we're seeing ICD-11 doing, then there actually is a technical solution that could be implemented to have all of those things reported back using identifiers that would come from this SNOMED expression library.

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

Yes, I like that Rob, but I still think we're talking about a future world, yes?

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

Yeah, I agree.

**Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine**  
Because it implies that the underlying record is coded in SNOMED concepts enabled to generate these expression couples in the first place.

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

What I was suggesting was that if the...again, let's think about CPT and ICD, so if the system is capturing CPT or ICD natively, if CPT...if those codes were linked to a SNOMED expression than it would be possible to have that SNOMED expression identifier submitted so there would be one code system expected in the context of the value sets for, again, let's say quality measures, but it would require that all of the code systems that are used to capture information natively have any expression that they might line up with, detailed expression, that this expression would be known.

And the reason why I'm suggesting this is that we're seeing for CPT that it is possible, although for what version of CPT I think that's a little unclear, and we're seeing for ICD it is possible but I believe it's only possible for 11 and therefore a future solution.

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

So, actually we...as Bedirh Üstün said, we can put ICD-10 CM in ICD-11 bottles. It is possible to make a linearization from the current ICD-11 infrastructure that walks and talks and quacks like ICD-10.

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

Oh, right, yeah, that's right.

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

So, the machinery could be leveraged for ICD-10 it's not...we don't have to wait for 11. But I still think we're back to the same conundrum, it basically would imply that this SNOMED expression is the reality and totality of the patient record when in fact it's just a derivative of this high-level administrative category that was generated and, you know, is a lossy transform but we'd nevertheless be rendering it and painting it as a fully robust SNOMED expression of what happened in the clinical record.

Maybe that's a pragmatic way forward anticipating a transition. I can see an advantage to that rather than, you know, veering rapidly to the right and then back again to the left and so on and so forth that could be very disruptive and not palatable. But, I think we have to be honest and say that even these expressions when they are published will simply reflect the data that was able to be put into an ICD or a CPT code and not necessarily reflect what was going on clinically.

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

Yeah, no...

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

So, this is Nancy...

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

Sorry, let me just say, yes, I agree with what you just said, Chris, absolutely.

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

Go ahead Nancy.

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

There are going to be certain organizations that are going to be faced with that conundrum. For instance if they're beginning to implement a Meaningful Use Stage 2 vendor that already has certain things natively in SNOMED, you know, the problem list is where I have concern, but may have legacy data for the next five years that's going to be problem list with ICD-10.

And so I was going to chime on with Rob and say, if this compromise thing where you can have a SNOMED expression for 10 and have it asterisks or something and said, you know, this is not a fully rendered SNOMED thing but it is a ICD-10 to SNOMED thing, that this may be useful for a lot of organizations who are in between, you know, just paid for the expense of 10 but don't have all the capability to go to the next generation Stage 2 things and vendors or you may have organizations that have part of their organization on the old way and part on the new.

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

I agree and I'm warming to Rob's idea. The implication however is that CMS and other persons or organizations would have to accept in a reporting context explicit expressions and to my knowledge I think, if you look at the NLM, you know, SNOMED map and so on and so forth they've focused entirely on pre-coordinated SNOMED expressions, they basically ignore the compositional world as have the vendors.

But if we...maybe the most useful outcome of this Task Force could be the recommendation that a single...to synthesize what Rob was saying, that a single reporting code system be proposed, that it would be acceptable to use federally published deconstructions of administrative codes like ICD and CPT into SNOMED expressions and that it be acceptable to include in that reporting and in fact it should be encouraged to include in that reporting SNOMED expressions not just SNOMED codes.

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

Can I...let me just make sure that we're clear about what I was saying and that expression while representing the proposed meaning of that...that other code system, that more complex idea, that in fact the idea of the expression library was that the expression would live in the library that you would be receiving an identifier that's a single identifier and so the technical win there is that the machinery that does not understand what an expression is could continue to be blind to that because they would get a single string identifier that looks exactly like a SNOMED identifier in order to shift around.

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

I hear you and I think that might be very practical Rob but think of the implications now we're talking about two reporting environments, we're talking about SNOMED so you can report SNOMED codes or the strange and mysterious expression library, which are not SNOMED codes you were very clear about that, it may be managed and sponsored by, you know, the IHTSDO as an expression library but the identifiers would not necessarily be SNOMED codes.

If we could find our way clear of having SNOMED embrace those expression identifiers as...SNOMED codes that would finesse a lot of angst but I have some pause that some of the reported stuff would be SNOMED and some of the reported stuff would be an expression library identifier.

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

That's exactly right...

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

Yeah, this is Marjorie...

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

And your angst is correct but it...

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

I have...go ahead Rob I have a comment after you.

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

Yeah, no I was just going to say, you know, these are I think one of the reasons why this particular project, which I think did reach a conclusion was not fully adopted at IHTSDO and none of the solutions that we've been faced with considering are fantastic. So, it's a choice of...

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

Yeah, so I want to recap the hybrid recommendation if I can, I might not have interpreted it correctly, but we're recommending a single vocabulary recommendation you report in one but if you use the alternate vocabulary such as CPT or ICD-10 at some point in time those would be deconstructed into a SNOMED expression. Is that correct?

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

That's right, that's what I'm suggesting.

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

Right, I do...

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

In being simplistic I'm saying either we send...we allow this sending of CPT codes or we could allow the sending of these hybrids.

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

I don't...I mean, I think we need to be further away from the middle maybe closer to, I don't know what direction it would be the right or the left depending upon where you sit, but what would be the harm in having...not using the word transitional but also having some alternate for certain types of items that need to be reported for quality measurement or whatever.

I think what we should do is take our recommendation and look at...what slide was it that you had Chris, the one with the recommendations and kind look at the things that need to be reported and does this recommendation actually fit or work with those types of things?

I am concerned that reporting expressions...it's hard for me to see a date where that would be possible.

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

Well the date...it could be possible tomorrow if the federally supported or published look up table for any ICD code it would give you the sanctioned SNOMED expression.

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

Right, but I'm looking at the healthcare systems or the systems and users that actually need to do that. Who actually does the translation or uses the expression? Who does that?

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

Well, it would probably be, what are they called these things, these consolidation houses that handle, find actual transactions and reporting for organizations. I mean, technically it's trivial, but by the way we are at four minutes before the hour. I think this has been a very wide ranging and fruitful discussion. We do need to accommodate time for public comment and unless there are objections I suggest we continue our discussion on the second and engender or engage public comment at this time.

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

Thanks, Chris, Lonnie or Marcus can you open the lines?

## **Public Comment**

### **Jaclyn Fontanella – Virtual Meetings Specialist – Altarum Institute**

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

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

Thanks, Jaclyn, sorry.

### **Jaclyn Fontanella – Virtual Meetings Specialist – Altarum Institute**

Oh, no, it's okay.

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

Well, it looks like we have no public comment.

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

All right, thank you everybody. I will not even attempt to summarize this discussion but I thank you all for your participation. I look forward to joining you on December 2<sup>nd</sup> and I don't envy Floyd the task of chairing our final meeting before the Standards Committee reporting deadline. We have many, many pressing issues and thank you again for your participation.

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

Thank you.

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

Thanks, Chris.

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

Thank you, Chris.

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

And Happy Thanksgiving everyone. Thanks.

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

Yes, same to all.