

Vocabulary Task Force and Clinical Quality Workgroup
Draft Transcript
August 30, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning everybody and welcome to a joint meeting of the clinical quality workgroup and vocabulary task force. This is Federal Advisory call so there will be opportunity at the end of the call for the public to make comment. Workgroup members please identify yourselves when speaking.

Let me do a quick roll call: Jamie Ferguson?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Betsy Humphreys?

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jim Walker?

James Walker, Chief Health Information Officer, Geisinger

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Clem McDonald?

Clem McDonald, National Library of Medicine

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Stuart Nelson?

Stuart Nelson

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marjorie Rollins? Stan Huff? Chris Chute can't make it today. Mark Overhage?

Mark Overhage

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Dan Vreeman? Beth Franklin?, and Juliette Rabini?

Beth Franklin and Juliette Rabini

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Don Bechtel?

Don Bechtel

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Patty Greim? Chris Brancato? Amy Gruber?

Amy Gruber

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Ram Sarong? Lynne Gilbertson?

Lynne Gilbertson

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Nancy Orvis? Marjorie Greenberg?

Marjorie Greenberg, HHS/CDC

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Pam Cipriano?

Pam Cipriano

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Karen Kmetic?, Anne Castro?, Eva Powell?, Joe Renner? Andy Rosenthal?

Andy Rosenthal

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Rosemary Kennedy?, John Derr?

John Derr

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Did I leave anyone off?

Ok, I will turn it over to Jamie Ferguson and Jim Walker.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Thank you Judy, I will do a brief intro and then I'll hand it off to Jim and he will go to the bulk of this call today. Just for those who were not able to join us yesterday here's a brief recap. The overall purpose of these calls is to establish a complete set of recommendations and transition pathways to a cohesive set of standards for vocabulary to be used in quality measure reporting. The scope is limited to quality measured reporting in the meaningful use program so the recipient of the quality reports and measures would be CMS. We did make a set of recommendations to the standards committee in the last standards committee meeting and the recommendations were for the long-term target set of standards and those recommendations were accepted. Subject to a couple of conditions, the main condition being that we come back and describe a plan to get to a set of transition plans for those who are currently using alternatives to those standards and for the cases where there may be other reasons to include alternative vocabularies in a transition plan to help move the industry towards the cohesive set of target standards. On yesterday's call we went through the subject areas and validated which subject areas require transition vocabularies to be allowable on the recommended standards. We went through that exercise yesterday, today we will take a look at the areas where transitions are required and we want to ultimately, for all of the different stakeholders to would have an impact, who would be impacted by this kind of transition we want to look at the kinds of resources that are available in the transitional allowable vocabularies such as cross maps, subsets, as well as the possibility of certification functionality to facilitate the adoption of the targeted standards. So we will go through that ultimately for the transition vocabularies and then after considering the tools and aids that might be available for implementers then we can come up with a recommendation on the date for final transition to the targeted standards. Jim, what did I leave off in that description?

James Walker, Chief Health Information Officer, Geisinger

That was great. I think if we could go to slide 9 we could show everyone the specific transition vocabularies that we identified a need for and everybody can see that under those specific categories within the quality data model of NQF that we believed those transitional vocabularies were needed for. I suppose one of the things that we could do perhaps quickly we went through all of the categories, about 23, and felt except the ones named on this worksheet on slide 9, no transition vocabulary was required. I think maybe the first order of business is to make sure that no one either who was on the call yesterday or who was not able to join is aware of any of the other categories that would need a transition vocabulary to make the burden of making all of these transitions manageable. If anybody on the call is aware of any additional vocabulary that we should consider making a transition or interim vocabulary.

Pam Cipriano

We were going to ask Beth Franklin to see if she had any additional information for the question that came up yesterday about Hicks Pix.

Beth Franklin and Juliette Rabini

Actually we do have some additional information, Hicks Pix is used in 15 of those retooled measures that we have been working on, so it probably needs to remain on the list.

Marjorie Rallins, AMA

I had trouble getting in, and had a "to do" with Hicks Pix as well. Some of our measures do include the Hicks Pix codes.

James Walker, Chief Health Information Officer, Geisinger

Pam, are we able to change that slide live?

Pam Cipriano

I would have to talk to Judy.

Judy Sparrow – Office of the National Coordinator – Executive Director

I don't think so unless Caitlin – I think she would have to take it down.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

We can just assume a bottom row that says –

James Walker, Chief Health Information Officer, Geisinger

Pam and Jamie, please help me remember it's down there and not let me get past it. Any other vocabularies that we need to make the transition manageable for any of the stakeholders?

All right, why don't we go back to slide one, actually we can go through slides 1, 2, and 3 fairly quickly. That's who all of us are and slide 4 is where the business end is. Just to restate what we are trying to do is make sure that we have identified in the vocabularies and transition plans for them to decrease the burden of what would be a large burden for organizations moving into the new world.

Slide five, what we have tried to do and this comes out of the discussion yesterday but undoubtedly needs discussion and refinement. What we have tried to do here is identify the various stakeholders who will be affected by all of these changes and who response to these interim transition vocabularies needs to be clarified in advanced. So this is an attempt to summarize what we talked about yesterday. So the first set of stakeholders, in no particular order, are measure developers and we believe they would not be required to use the interim transition vocabularies but they might want to do so voluntarily just to make it easier for their measures to be implemented. So I guess for each one of these we should pause and let anyone make comments on misinterpretations, ways to improve these assumptions. Everybody on the call is comfortable with the idea that these vocabularies would not be required for developers?

Pam Cipriano

As you indicated we had a similar conversation with CMS and they are going to encourage a new measure development and retooling to use in their sets for two reasons just like you've stated. It might make it easier to implement in the future but also it will help us in the testing phase that as they're using the recommended vocabularies they may uncover some issues that would help us in the refinement process.

James Walker, Chief Health Information Officer, Geisinger

Okay, and by recommended you mean acceptable interim vocabularies?

Pam Cipriano

Yes.

James Walker, Chief Health Information Officer, Geisinger

We are trying to be careful with our language. These are acceptable but in few cases mandatory are required for anyone so these are ways of making most groups life easier not a way of complicating it.

Pam Cipriano

If their ability to see if the adoptive code sets that were presented to the standards committee are adequate to express those, the data elements. Not the interim but the recommended and now adopted vocabularies.

James Walker, Chief Health Information Officer, Geisinger

Maybe for this discussion I think Jamie's language is useful if we call them target standards or where we want to end up as opposed to these interim or transitional standards that are at the outset. Obsolete but their pass due date has not arrived yet. Any other thoughts about the measure developers?

Let's go to HIT developers. My interpretation was that they would not be required to be able to manage interim vocabularies and certification but again, they may already be managing many of these vocabularies and their need to be competitive may motivate them to be able to manage these interim vocabularies, but that will be a separate question. Any thoughts on that?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

I think that the transitional vocabularies that we have identified are ones that actually are required for other functions, so they are all required for purposes of the HIPAA administrative simplification vocabularies and code sets. So I wonder if, I'm just thinking about number 2 and number 3 on page 5, because they are, if we should recognize that they are required the developers and certifiers for other functions but not for the quality measure function so because essentially they are required for the other functions, I was going to bring up in number 3 but will look it up under developers, the idea that it may be useful to add functional requirements for using a cross map to essentially get to the quality measure target standards from there must be used for administrative simplification.

James Walker, Chief Health Information Officer, Geisinger

Okay, maybe we could take this apart into 2 questions. Number one, Jamie, you are proposing changing the wording to something like they are already required to manage all of these interim vocabularies?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Well, I think whether they are or not depends what functions are going to end up in later stages of meaningful use, it is not required for critical care.

James Walker, Chief Health Information Officer, Geisinger

Maybe if we said would not be required for quality reporting to manage interim vocabularies?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Right, but it might be required for other purposes.

James Walker, Chief Health Information Officer, Geisinger

Pam do you have that?

Pam Cipriano

Yes, not required for quality measure reporting but it might be required for other purposes.

James Walker, Chief Health Information Officer, Geisinger

Right, thanks. That would apply to 2 and 3 right?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Right.

James Walker, Chief Health Information Officer, Geisinger

The other part of the question then, I've lost it –

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Essentially the idea, it's a question of whether EHR certification should require the ability to use a cross map,

James Walker, Chief Health Information Officer, Geisinger

Right, thank you. Any discussion on the question? I will take a whack and maybe prompt some discussion. It would seem to me that we would want to be careful about requiring use of mappings. If we provide them as tools that can be used if they help IT developers or whomever to function better, more accurately, that would be great unless – I think that we have to be careful mandating the use of something that I am not sure we have field tested extensively.

Patricia Greim, Veteran Affairs

I think we want to be very cautious about mandating methods. I think we need to stay focused on certification related to meeting the outcome and target rather than how.

Clem McDonald, National Library of Medicine

I would agree.

James Walker, Chief Health Information Officer, Geisinger

I guess that one way to clarify it is to say we want to hold ourselves and the other responsible groups responsible for providing useful value sets, subsets, mapping, but not on the other side require that they use them.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

That is great with me. I wanted to make sure we had the discussion.

James Walker, Chief Health Information Officer, Geisinger

Great, any other thoughts either way on that?

Marjorie (Unidentified Last Name)

I would agree it is important to make sure that people understand that maps are available because there might not be general knowledge that they are.

James Walker, Chief Health Information Officer, Geisinger

So maybe on the parking lot we need to think carefully on dissemination. Are there any thoughts or comments? All right, I think we are going to say that our consensus is that we and others are absolutely required to identify useful support tools but we will not require the use of any particular support tool like value sets, subsets or mappings.

Slide number 6, there are 3 more stakeholders that we identified and obviously one of the questions is did we miss an important group of stakeholders? Again just to be clear, care delivery organizations would not be required to use any of the interim vocabularies. We ran into this when we were creating the measures we created exclusions so that the denominator would not be full of patients to whom the measure was not even applicable and thereby degrading the organization's performance. John H. came back and said that those exclusions are an incredible amount of work and I'd appreciate it if they did not exist. The issue there is to say they are meant to be – if they help you use them, but if they do not don't use them. I think that is the background here. Is there anything different about care delivery organizations that we would want to say? Pam, I apologize I introduced the word interim instead of transition and on all of this we should call it, transition vocabulary so it is consistent.

Pam Cipriano

Ok, that is fine.

James Walker, Chief Health Information Officer, Geisinger

Hearing none we will move to CMS. It is our understanding that CMS would be required to receive in credit reports of clinical quality measures that were communicated either in the required standard vocabularies or in the transition vocabularies. It seems from the discussion yesterday that the major impact this would be on CMS. But for others the use of the transition vocabularies would be optional but for CMS they will have to be able to deal with them. Any comments? Anybody from CMS on the call? I think that the discussion yesterday indicated that CMS has been involved in the discussions and is at least aware of this, any other input?

Amy Gruber, CMS

I work at CMS however I do not work in the quality measure group. What I can do is touch base with them if you would like and get back to you with a response.

James Walker, Chief Health Information Officer, Geisinger

Great. I am not sure at what level, Judy, we probably ought have the right level of conversation with CMS early to work through the implications. It is not clear how we can have these transitional vocabularies without it creating extra work for CMS but we need to probably have that discussion. Jamie, before the September standards committee meetings so that we have worked that out?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Let's see when we can get it scheduled.

James Walker, Chief Health Information Officer, Geisinger

Okay will take that offline.

Pam Cipriano

I can send you the names of the individuals that we have been communicating with and have gotten feedback.

James Walker, Chief Health Information Officer, Geisinger

Great, thank you. We will take that off-line but make sure we have the right conversations with CMS as timely as possible. Any other thoughts on CMS? If not then, actually I added this after the discussion to try to be as thorough as possible on our understanding of the stakeholders. My assumption was that non-CMS payers would not be required to receive quality reports in any vocabulary either transitional or standard. Just so that it is clear, we think that there are no required additional efforts for them because of this. Obviously like the others beside CMS it might be in their interest to be able to manage both. Any fixes on that?

Marjorie Greenberg, HHS/CDC

I guess just taking these all as a whole, the only group, well, the care delivery organizations could use them if they needed to but not required to and the preferences is that they would use the target vocabularies, I understand that. CMS is the only one that really has to be able to receive them as well as the target vocabularies but there seems to be a disconnect. If none of the developers, certifiers, other payers, nobody needs to accommodate them and yet somehow the care delivery organizations can use them and CMS has to receive them. I am missing something.

James Walker, Chief Health Information Officer, Geisinger

I think part of the idea is that many care delivery organizations and HIT developers are already using them. So for them it is a way of saying if you are already using CPT and you know how to use it then for some period of time if it allows you to manage your workload better, you can use CPT for some of these things. I don't think any of us envisioned any care delivery organization saying oh now we're going to start using –

Marjorie Greenberg, HHS/CDC

Of course not but if the certifier, it the standards, products or whatever don't need to accommodate them how could they use them? So that is where my disconnect is.

James Walker, Chief Health Information Officer, Geisinger

Well I think they would need mappings so they could say this quality measure came down with this required data in SNOMED and the mapping from SNOMED to ICD-9 is this and so we will send them this. That would be the idea. Whether that is less work? That is an open question.

Marjorie Greenberg, HHS/CDC

It seems to me we would need official mappings. That would be a critical part of this otherwise how would CMS know that they were getting the right things if none of the other developers, nobody else needs to accommodate these and yet you can report them. You don't want everybody for themselves. Maybe I am only one that sees this as a disconnect, I understand why we're doing it because it's interim or transitional and trying to facilitate people who did not make that transition to target vocabularies, but I think there is a missing piece here but if nobody else thinks so then maybe I have to think about more.

James Walker, Chief Health Information Officer, Geisinger

Other thoughts or responses to Marjorie?

Patricia Greim, Veteran Affairs

Am I hearing your concern is that we are sending mixed message?

Marjorie Greenberg, HHS/CDC

In a way it is a mixed message in that you don't to tell people that they can do something and that there's not a logical way that it can happen. The developers would not be required to use these interim vocabularies so they don't need to accommodate them. That's the developers of the quality measures I assume. So that means they also don't need to worry about maps or whatever they just don't need to take them into an account I guess. The HIT developers don't develop systems that can accommodate these interim vocabularies and the people certified also don't have to worry about them. So meanwhile the next group they care delivery groups can use them but in what context can they use them?

James Walker, Chief Health Information Officer, Geisinger

One of the things is that Jamie clarified about 2 and 3. What are the cases that at least many of the languages are already developers are required to demonstrate that they can manipulate them in certification. This is part of that, they are already part of the woodwork and so at least in large to some extent the tools that people have, you know you cannot stay in business if you can't do ICD-9.

Marjorie Greenberg, HHS/CDC

Then what we should say is that they are not required to do any additional work to manage them or something. Here it sounds like they could just eliminate them from their products and they just don't have to deal with them and that is not what we mean. What we mean is we don't see them being adversely

impacted because they are already using them. That's a very different thing than not required to manage them.

James Walker, Chief Health Information Officer, Geisinger

Right and I think that is what Jamie was saying.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

They are not required for quality measure purposes but they might be required for it administrative simplification purposes.

Marjorie Greenberg, HHS/CDC

I know but we are allowing the care delivery organizations in a transitional or interim period to use them for quality measurement purposes so those organizations involved in the quality measurement process and in developers developing the system and all of that do have to be able to accommodate them otherwise everybody will have to figure out on their own what is the right ICD code.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

That is exactly right. I think that is true for the current set of measures. So maybe just a different lens to look at this is that of the different measure sets that that are currently required and we anticipate them to be required in the future. So I think that we have heard that CMS is encouraging measure developers not to use essentially the administrative simplification vocabularies in new measure development but rather use the targeted vocabularies and yet essentially the current set of measures all use them. So they will have to use them for the current set of measures but not as the new measure. I guess that will diminish as the new measures get rolled out.

Marjorie Greenberg, HHS/CDC

Okay it might be the way that it is phrased in the context of the current situation and where we are trying to go. What I want to avoid is people being able to use these interim vocabulary however they want. If it requires a mapping then there should be an approved mapping. You know you don't want everybody to decide what SNOMED codes that are in the actual measures are actually equivalent to the transitional code sets because you will just destroy any comparability.

James Walker, Chief Health Information Officer, Geisinger

Great point. We will try to change the language of those so that they reflect this discussion and Marjorie will count on you to make sure we did. This is very useful. Any other thoughts about the stakeholders?

Okay let's go to slide seven. As we worked through this yesterday it seems that the minimum necessary elements for planning a vocabulary transitions if they are available, would be vocabulary subsets or value sets and we had a brief discussion and concluded that people's use of those two terms isn't entirely consistent and decided to use both to include that set of tools. Then as Marjorie pointed out we would clearly need a set of validated mappings that various and there are the 3 stakeholders that it seemed obvious would need to have access to the mappings and others might as well. Then, the final date of the interim period of the transitional period. And then certification implication it sounds from our discussion today that it needs to be there and it is. Are there any other elements of the vocabulary transition specifications or whatever you want to call them that we need to identify as part of these transition plans? Again certification implications are part of the worksheet so you could ignore the parentheses. We will have more opportunity if nobody has any comments right now as we are working through the worksheet it may come up that we need some other dimension of the plan.

Can we go to slide eight. This is something I wanted to check my understanding that my guess was that the length of time during which these transition vocabularies will be used will be too short for us to expect to be able to provide any of these services. So might identify currently existing mappings and it might be hard to develop and validate them and ? at least any extensive set of mappings in time to effect anybody's use of the transition vocabularies and the same thing with value sets and sub sets. Finally, certification obviously is to slow the process to influence this. If someone wants to comment then you're more than welcome but we should probably get on to the worksheet unless somebody –

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

Let me comment that it is conceivable that some mappings that are currently under development but have not yet been released for broad testing might be able to appear soon enough within the next six to nine months in order to be useful for people.

James Walker, Chief Health Information Officer, Geisinger

Thank you Betsey. Pam maybe we should change the language and say rather than it is too short we will need to pay attention to the time that it would take to perform any of these functions. So then we've left it open to like what Betsey says if there's something just over the horizon it might get here in time. Okay, so this is just more of a set of questions to ask ourselves than a position to take in any case.

So let's go on to slide nine, these are listed I think just opportunistically but we might as well start with ICD-9 diagnoses, probably none of them that are any more are embedded in people's current work than it is. My thought at least, would be that we would try to fill in each one of these cells for each one of the transition vocabularies and with the purpose of saying at least at the first pass we know of good tools for this one or we're fairly confident that there is nothing and we can at least identify gaps that we need to address and places where we have something useful. Is that, as a good way to precede?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Yes.

James Walker, Chief Health Information Officer, Geisinger

Okay will we will start with existing subsets and value sets. Betsey you may be the leading authority on that, do we have subsets and value sets that will be relevant to the condition diagnosis in family history?

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

Yes in the sense that I believe it is true that the core problem was on the SNOMED side that reproduces also it indicates where there are ICD-9 things that have the same meaning and there are conceptual maps between SNOMED CT and ICD-9 CM and there is a draft of published available of a more billing specific map between a subset of SNOMED CT and ICD-9 CM. In addition to all of that, there are definitely a number of commercial companies and services that have produced mappings one direction or another between ICD-9 and SNOMED. So, some of these things are embedded into products that people are using. Have any of these been fully vetted or tested as to their reliability for any purposes that would be relevant to this? I believe the answer to that is no.

James Walker, Chief Health Information Officer, Geisinger

Okay, thank you. Pam I apologize that should be ICD-9 CM. Any other awareness of subsets or value sets relating to ICD-9 CM?

Marjorie Rallins, AMA

The NQF folks might want to comment. With the retooling work from round one, there were numerous value sets and subsets associated for various diagnoses, so those are available and I don't know how we will repurpose them but they are available for ICD-9 CM, 10 and CPT.

Unidentified Woman

Excuse me Marjorie, is it true that some of those value sets are available were done both in ICD-9 CM and SNOMED CT?

Marjorie Rallins, AMA

Yes that is correct.

Marjorie Rallins, AMA

All of those I believe are available and posted on the CMS website because they were part of the retooling work.

James Walker, Chief Health Information Officer, Geisinger

How strong is the implication that if it is on the CMS website or if it is an NLM value set or subsets that there is some implied conformance with an acceptable standard if you use those? Is there any of that implication?

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

In the case of things that are provided by NLM or have been up to date what we do is provide a description of how it was produced and what level of validation if any it's had. We don't, that is not necessarily, and it's certainly not uniform across the different things that we produce so from my perspective you have to read what it is we're telling you about how each of these things are produced and reviewed or validated.

James Walker, Chief Health Information Officer, Geisinger

Okay. Marjorie I guess the same thing to be true of –

Marjorie Rallins, AMA

Well I can tell you two things that NQF who had the contract for the initial retooling work subjected the measures for public comment and if those public comments went back to the measure developer which then we had several conference calls to go over those comments and they also convened an expert panel to review the measures and the coding and the value sets and subsets were included in that effort as well. As a result of those two efforts we are involved in making updates to those value sets, subsets and to our measures specifications. So, that was a long-winded answer to they have had some additional level of review not necessarily against a particular standard but they have had the opportunity to be reviewed by the public.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

This is a question for Betsey. I am recalling a conversation that we had in the standards committee with the policy committee about what is in a problem list. The guidance that we got back from Paul Tsang was that the things that were documented in the problem list from the policy committee perspective were intended to be those things that in SNOMED would be called disorders or findings or situations but the array of other things that are found in a problem list in the wild. I am wondering has there been a check of the cross maps that we are talking about for the subsets or subsets themselves to ensure that there is alignment with that direction for alignment with the policy committee?

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

I believe that there has been some modifications of the core problem list in that direction and we certainly in terms of mapping from SNOMED CT we are focused to ICD-9 CM and ICD-10 CM. We been focused on the things that appropriately fall into those categories but I will verify this and get back to everybody.

James Walker, Chief Health Information Officer, Geisinger

Off-line it seems to me in terms of dissemination it would be useful if Jodi Daniels or whomever thought that it was appropriate to say granted at different levels of validation effort if you use one of the NLM or one of the NQF mappings or value sets that will be taken as a good faith effort to be a good citizen. Does anybody have any comments about that? It seems like things like that be guidance might be useful to people other trying to execute this. Okay, are there any other subsets or value sets for ICD-9 CM that people are where of?

Mappings then, Marjorie, Betsey and others are their mappings between the target vocabulary I assume primarily SNOMED here, perhaps LOINK and ICD-9 CM?

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

I don't think that in general the mapping between LOINK and ICD-9 CM if we are talking about the diagnosis portion. Are we still on diagnosis?

James Walker, Chief Health Information Officer, Geisinger

We are still on diagnoses ICD-9 CM and the mappings.

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

Clem is on the line so he can say something about that but I think that in some cases LOINK may in terms of measurements and assessments and things where LOINK itself would refer to another applicable vocabulary like we are talking about, the LOINK is the measurement and the question and potentially the answer would come from SNOMED CT in some cases. I think some of LOINK may also make reference to ICD-9 CM there, but not for the piece of it that we are recommending to use LOINK for.

Clem McDonald, National Library of Medicine

I agree with Betsey.

James Walker, Chief Health Information Officer, Geisinger

I just wanted to make sure that we had not failed to think about that. So just in terms of ICD-9 to SNOMED mappings, are those available?

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

I think that in general the ones that LMN has worked on are in the opposite direction. They don't go from ICD-9 CM to SNOMED, the focus of the mapping has been in the other direction and there are of course for a subset the things for ICD-9 CM and SNOMED we have mappings that could be appropriately be considered by directional that is we are depositing that in fact this concept in SNOMED CT is a synonym for this classification in ICD-9 CM although that is sometimes problematic because of the changing nature of the inclusions and exclusions on the 9 CM side over time.

James Walker, Chief Health Information Officer, Geisinger

Is anybody else aware of any other mapping that would be relevant here?

Danny Rosenthal

I did want to point out that NQF did a report in 2010 which was prompted by the I-9 to I-10 transition and appendix A has a code set mapping inventory which lists the source codes, target codes, status and map owner of the map and then publically available or not then panel comments from this so I think this appendix that is available on NQF website lists a lot of these in detail.

James Walker, Chief Health Information Officer, Geisinger

Can you send Pam or us a URL for that?

Danny Rosenthal

Yes.

James Walker, Chief Health Information Officer, Geisinger

All right, granted what sounds like some considerable availability of value sets, sub sets and mappings, what is the final date of acceptability for the use of ICD-9 CM for diagnosis and family history? If someone can help me, what are the things that would condition this? The absolute final date would be for MU3 2015, is that correct?

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

The requirement for people, Marjorie you must know.

Marjorie Greenberg, HHS/CDC

ICD-9 CM can only be used for discharges or whatever before 1 October 2013 when you have to move to ICD-10 CM. However, during 2013 or 2014 if you are submitting data prior for care or patient care previous to 1 October 2013 then you will still be using the ICD-9 CM code sets for that data. So it's really on the date of service or date of discharge. That is why CMS and other pairs will have to be able to accommodate both.

James Walker, Chief Health Information Officer, Geisinger

Great. Chris Chute made the point yesterday that if you are an organization that has to prioritize the transition to ICD-10 and transition to SNOMED for quality measures the ICD-10 translation represents the bulk of your income where as the transition into SNOMED represents a few percent. If your organization is only able to get one done by a October 1, 2013 pretty clear that it would be the ICD-10 version and so it might be that organizations who are trying hard would understandably not be in a position to report quality measures using SNOMED for some time after October 2013. That would be another potential reason to consider a longer window for this interim. Any thoughts about those points or other issues that people are aware of?

Marjorie Greenberg, HHS/CDC

I think that is what makes the mapping between SNOMED CT and 10 CM critical because even if you have not totally ? you could for value sets for the particular purposes you could begin to migrate to SNOMED CT. I think that it depends, I mean we should not allow a 9 CM for any encounters, discharges after October 1, 2013 because it is not allowed for administrative purposes so it should not be for quality either. I am not quite sure what the right timeframe is for allowing a 10 CM.

James Walker, Chief Health Information Officer, Geisinger

Thank you, let's focus on 9 CM right now. So Marjorie you propose that the final date would be October 1, 2013?

Marjorie Greenberg, HHS/CDC

Covering services before October 1, 2013. If you are reporting in December 2013 about measures for people who received care in June 2013 then you would be using 9 CM but for any services delivered after 1 October 2013 you should not be using a 9 CM.

James Walker, Chief Health Information Officer, Geisinger

On that analysis then the final date for ICD-9 CM would be October 1, 2014?

Marjorie Greenberg, HHS/CDC

Yes I am not quite sure how the measures work and how far back they go but if it is unlikely by October 1, 2014 that you be reporting any data prior to October 1, 2013 then that would seem reasonable.

James Walker, Chief Health Information Officer, Geisinger

Other comments on this?

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

I would assume that since we are focused on this primarily for submissions to CMS then perhaps CMS could verify according to their reporting requirements what would be the last date on which it would expected, legitimate or mandatory or where it would be permissible for you to be submitting stuff in 9 CM.

Marjorie Greenberg, HHS/CDC

You could probably have several years in which old bills I don't know what it is but it could be submitted but that is different from the quality measures. They will probably have to receive some 9 CM nine for some time but depending upon what the rules are. At the same time there are also approved generally equivalence maps or crosswalks between 9 CM and 10 CM, so I suppose from the point of view of quality measures there could just be a point that you would say we don't want any more 9 CM just 10 CM and it for some reason that there were records covered in 9 CM you could convert them into 10 CM. I don't know if this is desirable or not but it seems from the point of view of quality measures it is a narrower use case then how long they will be paying the bills.

James Walker, Chief Health Information Officer, Geisinger

Right, okay. Marjorie would it be reasonable to say that we would expect the last date that ICD-9 CM could be used for reporting quality measures to be one year after the last service could be reported in ICD-9, so I think that would still be October 1, 2014.

Marjorie Greenberg, HHS/CDC

Yes, that would be appropriate and they would have a better idea what their flow data is but that seems like at least a reasonable thing to propose.

James Walker, Chief Health Information Officer, Geisinger

Other thoughts on that or considerations that might help us? If everybody is okay then I think that is reasonable to approach it. We'll estimate that it'll be October 1, 2014 and ask CMS to comment on whether that will be reasonable to them. Certification and implementations, what kind of support in certification particularly would be specific to this need and not already covered by other certification programs? I am nervous here because this is the one I understand the least well out of all the others. Is the silence meaning that no one is aware of any certification implications that we need to address?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Well I think that this is a discussion that we had before where we agreed that we did not want to recommend mandating how to use these internally.

James Walker, Chief Health Information Officer, Geisinger

Okay great. Any other thoughts or comments on that? Okay, we have about 20 minutes until public review, it is typical that the 1st one takes a lot longer than the others so we'll see if that works out here. In terms of ICD-10 CM the 2nd route, the same set of quality data model categories or concepts, what about existing subsets and values sets? Is there something beyond Pam checking with Betsey and Marjorie to understand what the available ones are? Do we have a robust set available for ICD-10 CM?

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

In terms of, oh, we're talking about sub sets aren't we? We have underway, it is the same issue of subsets, the same subset on the SNOMED CT side, there is a larger subset effort to map SNOMED CT and so this moves us into the mappings to ICD-10 as issued by the WHO which is then going to be one of the source activities for a current project to map a heavily used sub set of SNOMED CT or a sub set that represents frequently seen problems to ICD-10 CM. That is the project which is ongoing now and involving actually Kaiser and NLM and potentially others.

Marc Overhage, Regenstrief Institute

One of the things that is nudging at my brain is we have this discussion that the mapping and value sets is the misalignment if you will, of the granularity of these different systems, whether SNOMED, ICD-10, ICD-9 in the implementations of that for what we're talking about in particular as you climb up the hierarchies in some of these things. I am not quite sure how to express that. I think everybody knows that it exists but what I am worried about is what the implementations for the quality measures are especially as we transition.

Patricia Greim, Veteran Affairs

I think that is a wise observation and I think that what Betsey has been describing in terms of the directionality of the mapping that is available from SNOMED to ICD-10 and the efforts there. The tragedy in my mind that as caregiving organizations put resources towards an ICD-10 transition they are unaware of the potential structures that would be available to support a SNOMED to ICD-10 transition and they are going to have incentives to transition into ICD-10 and leave the SNOMED transition for later and yet the transition for ICD-10 to SNOMED has no such structure support. So really there is a mismatch in terms of alignment of granularity and there is a mismatch in terms of where is the incentive.

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

I think that, I am not disagreeing with what was said but I think that part of, there is the issue both for 9 CM and 10 CM about the suitability of the granularity of those systems to actually represent the concepts that are required for the measures. So from my way of looking at it if we are in a situation, here we are dealing with the measures not the other issues, if we are in a situation where the degree of granularity required for the measure is not really obtainable from data where your only indication of the patient's condition is an ICD 9 or 10 CM code then all the mapping in the world does not help. In some cases it seems to me that the way people are going to generate the measures is going to be to take the information from other parts of the record, for example, using test results to identify the diabetic patient or using a method of trying to translate pretext entries into whatever is needed to compute the measure. I think people are all over the map on this aren't they?

James Walker, Chief Health Information Officer, Geisinger

I think that you're right. The way I console myself is that we are trying to minimize the mess and not kid ourselves that we can eliminate it.

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

Yes I guess I'm sitting here saying that if you are in a practice and literally have no other information about your patient except a diagnosis level ICD-9 CM code, with what was wrong with them and you had a high level billing information about what was done for the patient, I mean could you in effect compute the measure? Clearly as Marc has pointed out you cannot convert a general statement in a code or any vocabulary into the correct more specific statement in another vocabulary because you do not have the specifics to deal with.

James Walker, Chief Health Information Officer, Geisinger

Right. Marc, appreciating you bringing this up and making sure that we address that, is there any sort of action that we could take or that we might take that would help with this?

Marc Overhage, Regenstrief Institute

I was kind of struggling, I guess the question and it might be as we are looking at these interim vocabularies, one of them is we could just call it as an issue and say we have these interim vocabularies because we have to recognize that it's going to screw things up. The second thing that we could do is assess in this grid if you will in addition to the value subsets and mapping, the question is how far off is it? On a scale of 1 to 5 there is not a lot of gap so for example the procedures will find a smaller amount of gap or then we will find with diagnoses. Maybe part of it is terms of action items recognition and visibility that there'll be instability in the quality measures if we, as we use these interim vocabularies and perhaps in our recommendation some assessment of how big that the variability factor might be. That would be one thought.

James Walker, Chief Health Information Officer, Geisinger

Great, if I understand it right Marc for the existing subsets and value sets cells and the mapping cells we might add a cell for each of those which makes an estimate of how complete or adequate the existing subsets and value sets or mappings are to the need.

Marc Overhage, Regenstrief Institute

Yes that makes sense.

James Walker, Chief Health Information Officer, Geisinger

Great, anybody else want to follow onto this conversation?

Marjorie Rallins, AMA

Other than to reiterate what I said earlier, is that there are value sets and subsets for ICD-10 CM that came under the original retooling work and with respect to your comments about relevance, I think those are very relevant since they were developed for quality measurements.

James Walker, Chief Health Information Officer, Geisinger

Pam just for you it sounds like one of the things after this meeting that would be extremely useful would be to talk to Marjorie and Betsey and identify what the subsets and value sets for all 5 of the languages and mappings and how they would assess the adequacy of those. Probably one to five is fine, five is perfect and one is almost unusable. So that is one of the things that we could continue to drive off-line. Who besides Betsey and Marjorie should Pam go to to identify relevant subsets and value sets and mappings?

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

I think that the report that was mentioned earlier from NQF sounds like a source too.

James Walker, Chief Health Information Officer, Geisinger

Any other sources? Okay, let's go back to ICD-9 CM and make an assessment. If we have to assign five is everything that we need and one is almost unusable, how would we assess the subsets and value sets existing and just over the horizon as Betsey said for ICD-9 CM? Did somebody say 2?

Unidentified Man

On a scale to five Jim?

James Walker, Chief Health Information Officer, Geisinger

Yes five is perfect and one is barely usable.

Unidentified Man

I would say 2.

James Walker, Chief Health Information Officer, Geisinger

Okay 2, Does that sound about right people?

Unidentified Man

It does.

James Walker, Chief Health Information Officer, Geisinger

All right one of the things I will do is circulate this by e-mail afterwards for voting so that we could do a more thorough voting. We will put two in as our anchor point. In the mappings 1 to 5, what would be people's estimate on how usable or adequate the mappings will be to this need? Marc would it be different then two?

Marc Overhage, Regenstrief Institute

I think that it would be similar, the mappings might be a little bit better so it might be a three but again we are getting fuzzy.

James Walker, Chief Health Information Officer, Geisinger

In the nature of things all of this could be legitimately presented as an expert estimate of something that's extremely hard to estimate but at least give CMS and others a little bit of a heads up.

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

Given the fact that the issue is can we use as an interim – what measures are we talking about? The ones that were already done that Marjorie Rallins has referred to where we have got the value sets defined in terms of 9 and 10 CM where they are applicable and that looks like pretty good support but the next set that will have to be applied only going to produced using our target vocabularies? If so then the support for this is a lot less isn't it?

James Walker, Chief Health Information Officer, Geisinger

Right. Maybe what this estimate would be an estimate of the usefulness of the support when it is needed. If the existing ones for MU1 are a 4 or 5, maybe that's what the real number is and by all odds the next group ought to be better supported you would think then the first group were.

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

I think that we would probably have to vote from the more knowledgeable people like Floyd and Marjorie about whether we are at the four or five level for the ones done. It just seems like it would be a better

case than for a perspective measure or something that might be worked on that, for example a value set would only be provided in SNOMED CT.

James Walker, Chief Health Information Officer, Geisinger

Okay, for the interest of time let's take this off-line. We have some thinking about a measurement tools that would be useful and we will try to work on that and bring it back to the group. If anybody has any ideas they would be welcome. Maybe we could try to come up with an expected final date of acceptability for ICD-10 CM. When do we think it would not be reasonable for CMS to accept quality measures expressed in ICD-10 any longer? In terms of the meaningful use timeline when was that date that ICD-10 is no longer acceptable and only SNOMED CT is?

Marjorie Greenberg, HHS/CDC

Isn't it 2015?

James Walker, Chief Health Information Officer, Geisinger

I thought that it was in 2015. Can we imagine a legitimate reason that people would need to report quality measures in 10 CM beyond whatever that previously established date for MU is?

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

Would potentially be something similar to what Marjorie Greenberg walked us through before for the ICD 9 CM? If in fact you are able to use 10 CM in certain things up until then would we have to assume that you might need a year after that in terms of reporting?

Unidentified Man

Yes.

James Walker, Chief Health Information Officer, Geisinger

Any other thoughts about that? It seems to me that it makes sense partly to express to people that we really are going to get to the target vocabularies but we will not kill you along the way.

Marjorie Greenberg, HHS/CDC

So what you are suggesting October 1, 2014?

James Walker, Chief Health Information Officer, Geisinger

I think that the suggestion was a year after the 2015 date when ICD-10 CM is no longer acceptable for quality measures. I think that is the question, in that case it really is specifically related to quality measures that that deadline has been established.

Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine

Okay I see. Well then maybe that will be the deadline. I was thinking incorrectly.

Unidentified Woman

I think that you were thinking correctly, I think that the deadline for discharge and using them operationally in 2015 there will be a lag time of reporting retrospectively that we're accommodating with 9. I think that you are thinking right on target.

James Walker, Chief Health Information Officer, Geisinger

Beyond quality measures, what would ICD-10 CM become unusable in 2015? It'll still be used for billing purposes correct?

Marjorie Greenberg, HHS/CDC

It is intended to be used for all of the purposes for which 9 CM is currently used for the foreseeable future after 1 October 2013.

James Walker, Chief Health Information Officer, Geisinger

Does anybody else have any thoughts?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

I think that this discussion really needs to be informed by more members, Floyd and perhaps more other members of the measure developer community. What is reasonable from their perspective?

James Walker, Chief Health Information Officer, Geisinger

So it might be at the date that MU3 takes full effect, it might be a year after that. Who are the other people that we think we could get to off-line so when we start this up again in a joint meeting, we would have at least a set of considerations that would help us come up with an answer? Anybody besides Floyd?

Unidentified Woman

Bob Dolin?

James Walker, Chief Health Information Officer, Geisinger

Okay, all right, so that is where we will reenter this since we are one minute from public comment. Any other final thoughts about the process or ways that we can work at this more effectively? If not now but you do have something and you want to send them by e-mail we will try to incorporate them. Thank you all for careful attention to a tough and important set of questions and I think that Judy we are ready for public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director

Operator, can you see if we have any public comments please?

Operator

We do not have any comment at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay, thank you and thank you everybody.