

Vocabulary Task Force and Clinical Quality Workgroup
Draft Transcript
September 26, 2011

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you operator. Good morning or good afternoon rather everybody and welcome to a joint meeting of the clinical quality measures group and the vocabulary task force. This is a FACA Committee so there will be opportunity at the end of the call for the public to make comment. Just a reminder Workgroup members to please identify yourself when speaking. So quick roll call. Jim Walker?

Jim Walker – Geisinger Health System

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Karen Kmetik?

Karen Kmetik – American Medical Association

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 – National Library of Medicine

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Betsey Humphreys are you on yet? Jamie Ferguson? Marjorie Rallins?

Marjorie Rallins – American Medical Association

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Dr. Syed?

Dr. Asif Syed

Yes, here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Chris Chute?

Christopher Chute – Mayo Clinic College of Medicine

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Stan Huff? Marc Overhage? Daniel Vreeman?

Daniel Vreeman – Regenstrief Institute

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Floyd Eisenberg? Karen Trudel? Don Bechtel? Patty Greim?

Patricia Greim – Veterans Affairs

Present. I've changed my name to Trisha, Judy.

Judy Sparrow – Office of the National Coordinator – Executive Director

Oh Trisha okay, sorry, I'll make a note.

Trisha Greim – Veterans Affairs

Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director

Mike Sephir?

Mike Sephir – Social Security Administration

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Andy Wiesenthal?

Andrew Wiesenthal – IHTSDO (SNOMED)

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Chris Broncato? Bob Dolin? Rham...? Ken Gebhart?

Ken Gebhart – National Institute of Standards & Technology

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Lynn Gilbertson? Nancy Orvis? Anthony Oliver?

Anthony Oliver

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marjorie Greenberg?

Marjorie Greenberg – Health & Human Services – Center for Disease Control

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

David Baker? Anne Castro? Bob Dolin? Jean Nelson? Eva Powell?

Eva Powell – National Partnership

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Phil Renner? Danny Rosenthal? Joachim Roski? Rosemary Kennedy?

Rosemary Kennedy – Thomas Jefferson University

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marjorie Rallins?

Marjorie Rallins – American Medical Association

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

John Derr? Jon White?

Jon White - AHRQ

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Aneel Advani? Did I leave anyone off?

W

...

Judy Sparrow – Office of the National Coordinator – Executive Director

Who is that? How about Betsey Humphreys are you on yet please or Jamie Ferguson? All right Jim I'll turn it over to you but I'll send an email to the two of them.

Jim Walker – Geisinger Health System

Thank you Judy.

Judy Sparrow – Office of the National Coordinator – Executive Director

You're welcome.

Jim Walker – Geisinger Health System

And thank you to all of you. We appreciate your continued attention to this complex but very valuable work. If we could start on slide 4 I think that would maybe a useful place for us to start. Just as a reminder what we're doing now is trying to deal with the need for interim use or transition use of some already in use vocabulary so that we don't create any unavoidable burdens for organizations, and this is for all the stakeholders, as they make this transition to a set of standard vocabulary. So, just a reminder again on the bottom of slide 4 there that these recommendations are limited to the domain of clinical quality measure development and reporting. They don't have any other implications. Yes?

Betsey Humphreys – National Library of Medicine

Jim, excuse me this is Betsey Humphreys I apologize for being late.

Jim Walker – Geisinger Health System

Oh hi Betsey. Glad you're here. Thank you.

Karen Kmetik – American Medical Association

Jim this is Karen could I just add to that?

Jim Walker – Geisinger Health System

Sure.

Karen Kmetik – American Medical Association

Briefly, I just wanted to put a bit of an exclamation point on Jim's last comment about the scope from this slide. I think particularly as we speak to others outside of our Workgroup who might not be as familiar with the very specific scope of what we've been doing it's important just to remind everyone that all of the code sets that we're naming through this transition period are used and will be used in the future for different use cases and that's very important to recognize versus the scope of what we're working on. Thanks, Jim.

Jim Walker – Geisinger Health System

Okay. If anyone else, if we could just go quickly to slide 5 and 6, our estimates of effects on stakeholders are that while developers wouldn't be required to use the transition vocabularies they might want to do so in order to make measures easier to implement that HIT developers would not be required but they may already be using them and so obviously they're welcome to. HIT certifiers, it's hard to imagine a timeframe in which those would make any sense as part of certification and certainly aren't required. Care delivery organizations, again would not be required to use the transition vocabularies although obviously the point is that they may want to. CMS would be the one stakeholder that would be required to receive and properly process reports of, again care quality measures only, whether they were communicated in the standard vocabularies or one of the transitioned vocabularies, and then Non-CMS payers would obviously have no obligations just for completeness.

Then slide 7 to just remind us of where we are and what we need to do today, in our earlier work on August 29th and 30th we identified six transition vocabularies that would be acceptable to use for specific concepts in the quality data model and those six vocabularies and you'll be able to see the QDM concepts on each one of their slides, but the six vocabularies are ICD-9 CM, ICD-10 CM, and I'm assuming the slide is up now and you can see the rest of the vocabularies that we have decided earlier probably each of which needed a transition plan. Maybe we could stop quickly because all of this has been pretty quick. Does that still look like a reasonable list to people? Does anyone want to call out any change we need to make in that list?

Okay, then we'll continue to work through that list. On the first session we got fairly well through ICD-9 CM and ICD-10 CM. Then on slide 8, just as a reminder, we identified the minimum necessary elements that we wanted to at least consider when planning these vocabulary transitions. So number one, if there were any subsets or value sets of vocabulary that were already available or could be made available very rapidly. The second was if we could point to any mappings that would be useful and even perhaps authoritative for the various stakeholders. And then one of the tricks is to identify a final date of the transition period for each of the vocabularies and we have another slide about some of the criteria we had made explicit for trying to pick reasonable final dates. And then if there are any certification implications we wanted to address that and either spell out what we thought those were or just confirm that we don't see any for that particular vocabulary.

Then on slide 9 these are the considerations that we had been using to try to pick reasonable final dates for each of the vocabularies. And I will let you read those, but I think, again, it's worth giving everyone just a moment if we need to change any of those, add any, remove any. Does that still look like the kind of calculus were using to pick these terminal dates? All right.

M

They look good to me Jim.

Jim Walker – Geisinger Health System

All right. Great. Thanks. Obviously we want to move quickly but also leave plenty of opportunity for feedback. So, you just call me out if I get too quick. So then the final things we've been trying to do and you'll see it on the slides is rate the readiness of both the subsets and the mappings, identify the final date of acceptable use and certification issues. Just one thing, for the ratings we're using 1 as useless or unusable and 5 is it's hard to imagine one better.

Karen Kmetik – American Medical Association

Jim this is Karen. Just to throw out something related to the date, the terminal dates, to go back but just briefly.

Jim Walker – Geisinger Health System

Yes.

Karen Kmetik – American Medical Association

I think we all.

Jim Walker – Geisinger Health System

So this is slide 9 you're talking about Karen?

Karen Kmetik – American Medical Association

Yes.

Jim Walker – Geisinger Health System

Great.

Karen Kmetik – American Medical Association

I think we all recognize that the actual timeframe for example of government programs that are going to utilize quality measures in EHRs, today that is the EHR incentive program, the actual dates of those programs Stages 2 and 3 may evolve, and so I'm just sort of stating the obvious as to something we'll all need to keep in mind.

Jim Walker – Geisinger Health System

Right. Thank you. Yes. That's, yes we live in a dynamic world for sure. All right then slide 11 is ICD-9 CM and you'll see there at the top in italics the QDM concepts that we thought that ICD-9 CM would be potentially needed for during the transition, would be condition, diagnosis, problem, family history, and I'll probably quit reading of these to you. And then we, Betsey you probably need to talk to this, we went through this but I'm sure we got all of it rock solid, if, maybe Betsey you could start by sort of fixing this the way it needs to be fixed.

Betsey Humphreys – National Library of Medicine

Yes, and it's my fault it wasn't fixed in time for this. Basically, we were sort of lumping in this top category existing subsets and value sets which might help with the transition, and as far as I believe, I think we ended up with this reference to the core problem list in a way in the wrong category, in the sense that I don't believe, unless others on the call are aware of it, that we were discussing a, or problem list that was identified in terms of ICD-9 CM already. Is anyone aware of such a thing? What I am aware of is that NLM in collaboration with a bunch of people identified the most frequently occurring problem based on data from a variety of health systems and then we produced a SNOMED CT subset that corresponded to those. We can, there is extent, a conceptual mapping between that subset and ICD-9 CM where, and so we have partial mappings of that ICD-9 CM available now, perhaps not instantly, you know, up-to-date as of today, but they are probably useful for this purpose. I think they sort of belong down below in the mapping category perhaps not up here in the subset, unless someone else on the call is aware of, you know, a subset of ICD-9 CM which is considered to be the core set of problems.

Clem McDonald – National Library of Medicine

Betsey this is Clem. I'm not aware specifically but I do know some clinical systems use ICD-9 codes in their problem list.

Betsey Humphreys – National Library of Medicine

Oh, yes we know that, what I was just wondering was whether there was in fact, well first off if they're already using them I'm not sure, I'm not exactly certain what a subset of ICD-9 CM that focused on problems, that's already being used by a variety of players.

Clem McDonald – National Library of Medicine

No I agree with you, but it might be worth making a comment in here somehow so people aren't, you know if you say look it doesn't exist look elsewhere, say something to explain, you could, you could do, I don't know what you want to say, but.

Betsey Humphreys – National Library of Medicine

Well my question really is if people are already using 9 CM and people are writing quality measures using SNOMED CT, based on the various recommendations here, I'm not exactly certain what a subset of 9 CM that represents frequently occurring problems how that actually contributes to an effective transition.

Jim Walker – Geisinger Health System

I see what you're saying Betsey, or well I think I do, let me try. So this is Jim. So what you're saying is the thesis, the foundation of all of this is that they're already using ICD-9 CM and the other five also, and so subsets and values sets from the care delivery organizations stand-point may not be very important. What about from the quality measure developer's stand-point?

Betsey Humphreys – National Library of Medicine

Well the way I'm thinking about it is that if the thesis, which I, I mean I think it's more than a thesis, it's a fact, that we have certain members of health systems, people, practices that will want to report, need to report quality measures, and they're using, in the case that we're on right now, they're already using ICD-9 CM to record the patient, items about patient's that are relevant to quality measures, and they're not going to be necessarily fully transitioned or in a position to use SNOMED CT instead when they're reporting those quality measures for a certain period of time.

Jim Walker – Geisinger Health System

And what a quality measure developer would need you're saying is a mapping from SNOMED to ICD-9 CM?

Betsey Humphreys – National Library of Medicine

Well.

Jim Walker – Geisinger Health System

So that they can.

Betsey Humphreys – National Library of Medicine

If the quality measure people are developing their quality measures using SNOMED CT then theoretically they don't need the map, although if they were trying to provide it in more than one, you know, I mean if they were trying to give people a definition in SNOMED CT...ICD-9 CM that might be helpful to them. So, it seems to me that the people who are reporting the quality measures if they have, if they say during a transition period given where we are we must report our quality measures using ICD-9 CM, then they will have to have some method of translating numerators and denominators that are presented in the quality measures in SNOMED CT into something that will work in their environment with whatever they're using.

Jim Walker – Geisinger Health System

So let's see.

Betsey Humphreys – National Library of Medicine

Am I right?

Jim Walker – Geisinger Health System

Well, so, what I'm thinking is, is if I'm a measure developer.

Betsey Humphreys – National Library of Medicine

Yes.

Jim Walker – Geisinger Health System

I need to develop in SNOMED so that it has legs, but I might also want a mapping to ICD-9 so that I make it easier for care delivery organizations to use their current ICD-9, which they are using and know how to use, to let them report in ICD-9.

Betsey Humphreys – National Library of Medicine

Yes, so I agree with you that the mapping from SNOMED CT, whether it's developed by the measured developer or whether it's developed by someone else would certainly help, and the question, and the issue of whether we have a good mapping for those things is something that can be determined if we

know in essence the, if we have the list of SNOMED CT things that are in the quality measures. Do you see?

Jim Walker – Geisinger Health System

Right.

Betsey Humphreys – National Library of Medicine

There are.

Jim Walker – Geisinger Health System

It would be a very constrained set of codes that you would need.

Betsey Humphreys – National Library of Medicine

Yeah. See the thing is there are mappings in SNOMED CT and ICD-9 CM but I would not call them comprehensive. So the question then is given the set that are needed for the quality measures how close are we and without the list that are needed for the quality measures it's hard to determine that.

Jim Walker – Geisinger Health System

So if I could state this, let me try to state this for discussion. I hear you saying, Betsey, that subsets and value sets are really not needed here because the care delivery organizations are already using the vocabularies that's the whole point and as far as mappings it would be measure developers who would need mappings to go from the SNOMED that they're presumably going to code these quality measures in to ICD-9 so that care delivery organizations can start reporting earlier rather than later.

Betsey Humphreys – National Library of Medicine

And I guess the question is you could turn that around, Jim, you could say the measure developers need them or you could say that care organizations need them so they can.

Jim Walker – Geisinger Health System

Right.

Marjorie Rallins – American Medical Association

This is Marjorie Rallins. I'd like to know if you, what anyone thinks about the other direction of going from ICD-9 for the reverse map from I-9 to SNOMED for the care delivery organizations or anyone that needs to sort of translate their administrative data and to the vocabulary.

Jim Walker – Geisinger Health System

Right.

Marjorie Rallins – American Medical Association

I don't see that direction here and I think that's something we need to think about.

Betsey Humphreys – National Library of Medicine

You know, I would agree with you Marjorie, that's a very good comment and I think that we really do need to look at this in terms of the subset of SNOMED that's required for some set of quality measures that are of interest to us, because I think that in some cases, you know, so that we can in effect identify if a mapping will work correctly, particularly in the case of ICD-9 CM, or whether in effect there will almost be a requirement to start with a certain set of records that you can identify by the, you know, a certain set of records you can identify and then actually go looking for some more detail elsewhere in the record to report them then.

Marjorie Rallins – American Medical Association

Right.

Andrew Wiesenthal – IHTSDO (SNOMED)

This is Andy.

Jim Walker – Geisinger Health System

Great.

Andrew Wiesenthal – IHTSDO (SNOMED)

I'm just listening to the conversation and you know, Jamie's not on the call unless he has chimed in since we did roll call, so I feel free to offer Kaiser up as a possible place to figure this all out since I'm not there anymore. You know, they've been, their electronic health record system is essentially SNOMED CT based almost all the measures that they have to report on to every regulator and every creditor, and everybody else are spec'd in ICD-9, and they have an inherent mapping between the two for those purposes and so if somebody wanted to look at how did they actually do that they may be able to come up with both the SNOMED codes that walked into the ICD-9 CM codes and vice versa. You might quibble with it but at least it's a starting place.

Betsey Humphreys – National Library of Medicine

I would agree. This is Betsey again. I would agree with Andy that there's probably very useful material there and I think that one of the that will be, as I said before I consider as a very good first step is to come up with something that loosely approximates the set of SNOMED CT that we will actually be using in some set of quality measures that are the ones that we're first aiming for.

Dr. Asif Syed

Hi this is Asif, just a quick comment, so what we are talking here is more like a subset of mapping not really a simple subset, a full set of mapping.

Jim Walker – Geisinger Health System

Correct. I think that's what's being discussed, actually a very constrained set of codes that would need to be mapped.

Betsey Humphreys – National Library of Medicine

Well the reason why I'm approaching the problem that way is because it seems like at least in the case of ICD-10 have, and some of these others we have plans underfoot to produce larger subsets, and in the case of 9 CM we have larger subsets, but I'm not sure that even in these larger subsets we have 100% of what we need for the quality measures and so, and obviously going forward it will be useful to be sure that as we work on the 10 CM mapping that we sooner rather than later get to the pieces that are most important for these quality measures.

Marjorie Rallins – American Medical Association

And this is Marjorie. One additional comment. I think that, again the direction of the map is important forward or I think the reverse map is an immediate need for those and not only for ICD-9 but to the other administrative code sets like 10 and CPT.

Jim Walker – Geisinger Health System

So this is Jim. Let me, I, let me just see if I can clarify and make sure I understand at least. So, right now we're saying there are no relevant subsets and value sets that in terms of mappings we would need SNOMED CT to ICD-10 CM, SNOMED CT to ICD-9 CM, and ICD-9 CM to SNOMED CT, are those the three or are there others? Or did I just get that totally wrong?

Betsey Humphreys – National Library of Medicine

Well. I think that what Marjorie is saying that for many of these items that are in current use, including CPT and so forth, we also need mappings from them to SNOMED CT.

Jim Walker – Geisinger Health System

Yeah, absolutely, I just want to stay on slide 11 for right now and just address ICD-9 CM if we could.

Betsey Humphreys – National Library of Medicine

Yeah. So if we're addressing 9 CM I think what we've heard is we need them in both directions.

Jim Walker – Geisinger Health System

So we need SNOMED to ICD-10, we need SNOMED to 9, and we need 9 to SNOMED.

Betsey Humphreys – National Library of Medicine

I don't think 10 comes into it here does it?

M

No.

Jim Walker – Geisinger Health System

I thought part of our discussion last time was that if somebody really has worked very hard and moved all of, made the transition to 10 they would need to be able to use 10.

Betsey Humphreys – National Library of Medicine

Yeah, well we were thinking, again on your principal of stick to the right slide, I would think that one is the next slide.

Mariorie Rallins – American Medical Association

Yes. I would agree.

Jim Walker – Geisinger Health System

Oh, thank you.

Betsey Humphreys – National Library of Medicine

Yes. Yes.

Jim Walker – Geisinger Health System

Absolutely.

Betsey Humphreys – National Library of Medicine

So, I think we ended up mentioning 10 here and I'm not sure we should.

Jim Walker – Geisinger Health System

You're right.

Betsey Humphreys – National Library of Medicine

Yeah.

Mariorie Rallins – American Medical Association

Right. I think, the high level point that I wanted to make is the existing maps don't include the subset and the maps are not bidirectional, they're not equivalent maps, they're all rule based for the most part.

Jim Walker – Geisinger Health System

Right. All right. So.

Mariorie Greenberg – Health & Human Services – Center for Disease Control

Anyone, could I just ask a question.

Jim Walker – Geisinger Health System

Yes.

Mariorie Greenberg – Health & Human Services – Center for Disease Control

This is the other Marjorie. Is anyone working on mappings in the other direction? Obviously this is challenging.

Betsey Humphreys – National Library of Medicine

I can only say this Marjorie that we at NLM feel that if in those cases where we need the mapping in the other direction that what we would do is start mapping in the one direction and then have to go through and do editing, make it work in the opposite direction.

Marjorie Greenberg – Health & Human Services – Center for Disease Control

Okay.

Marjorie Rallins – American Medical Association

And Marjorie to answer your question I think reverse mappings usually happen locally, you know, they probably exist but we're not aware of them.

Marjorie Greenberg – Health & Human Services – Center for Disease Control

Okay.

Jim Walker – Geisinger Health System

Okay, other discussion? So if I understand now we just have two mappings basically, SNOMED to 9 and 9 back to SNOMED, and is everyone comfortable with that, is that. How would we estimate the readiness, Betsey or other people who know this, what would the readiness of those two be?

Betsey Humphreys – National Library of Medicine

The question here that I feel that is an interesting one is that.

Jim Walker – Geisinger Health System

Hello?

Betsey Humphreys – National Library of Medicine

I believe that if we knew the subset that we cared the most about to do this quickly of SNOMED CT then we would have a basis for making sure or determining whether the combination of things that are public...like what Kaiser has available and is making available within CMT are very...and we would also have a basis for determining or at least asking the extent to which a number of the EHR products may have useable things because they've already implemented them for their customers.

M

Well can we take up the offer from Kaiser?

Betsey Humphreys – National Library of Medicine

Yeah, I mean the offer from Kaiser is there because the mappings to 9 CM I believe are among the stuff that is being gradually turned over more, you know, and a lot has been turned over in terms of the donation of CMT. I think the issue, again is if we, if I could somehow put my arms around a rough approximation of the SNOMED CT we need for whatever the next set of measures is then I suspect we could work with Kaiser to make more of it available sooner if it isn't already.

Jim Walker – Geisinger Health System

So one of the take aways from this that we will absolutely get memorialized is that MU 2 measures this as soon as they are set or even highly likely in their, you know, in their semi-final form, we need to get to you Betsey in 10LM.

Betsey Humphreys – National Library of Medicine

Because it's hard for us to tell, I mean, and looking at them, depending on what they are, it may be that this is relatively speaking, you know, either an easier or a harder problem to solve for people.

Jim Walker – Geisinger Health System

Right. Any other discussion on that? So, I think, according to your point we have for sources, I think we have NLM, Kaiser, and then you know the commercial maps that may already be in some products. Any

other thoughts about sources? And I guess from what you're saying Betsey readiness we don't know would be the only honest answer at this point.

Betsey Humphreys – National Library of Medicine

Yeah, I mean, I don't...statement about that. And of course it could be that we would discover that for some subset of the measures that are of concern all is well and for others it's much more problematic.

Jim Walker – Geisinger Health System

Right. Okay. Okay other thoughts, concerns? So if anyone is aware of other sources speak now or send an email to me or Betsey, or Judy Sparrow, or whoever's email address you know. All right, final date of acceptability, I think we were fairly comfortable that October 1, 2014 was reasonable, although the idea there is that that will be a year after ICD-10 is required and maybe that doesn't belong on this slide either, but the idea was that, that would give people a year after they got over the ICD10 CM hump and probably was as long as it made sense to string this transition out, but maybe that's the next topic for discussion. Does that still look reasonable to people or do we need to think about something else?

Marjorie Rallins – American Medical Association

I think the question is, by October 2014 would the quality measures that need to be reported, or that we're talking about, cover any data or patient experience prior to October 1, 2013.

Jim Walker – Geisinger Health System

Right.

Marjorie Rallins – American Medical Association

If not then this date makes sense. So it's really, that's really the question, if you're going back, if at that time in 2014 you're reporting on some of the quality measures that cover a period prior to October 1, 2013 then we should still allow them to use 9 CM because that's the date it was coded in, that's the classification that was being used then. And, I don't know what the timeframes are on these quality measures.

Jim Walker – Geisinger Health System

So, Marjorie, you're saying that a better statement of that would be one year after all services were reportable in ICD-10?

Marjorie Rallins – American Medical Association

Yes.

Jim Walker – Geisinger Health System

Is that what.

Marjorie Rallins – American Medical Association

Well what I'm saying is you should only, if you have the option of using 9 CM it should only be during for data covered by the time period in which 9 CM was enforced.

Jim Walker – Geisinger Health System

All right, let's say it there. One year after, or.

Marjorie Rallins – American Medical Association

Why are you giving just the year?

Jim Walker – Geisinger Health System

Yeah, you're right.

Marjorie Rallins – American Medical Association

I would say you do not want people to be using 9 CM say for a quality measure that is covering the first quarter of 2014 or something, because they're not supposed to be using 9 CM then.

Jim Walker – Geisinger Health System

No you're right. So say to report.

Nancy Orvis – Director Health Standards Participation – Department of Defense

You could say at the industry effective date.

Jim Walker – Geisinger Health System

Services provided.

Mariorie Rallins – American Medical Association

It all has to do with the quality measures what's their time, what's covered, what time periods they cover.

Jim Walker – Geisinger Health System

Right.

Clem McDonald – National Library of Medicine

Well to suggest and I thought I heard just a minute ago is to make it general, reference the industry effective date isn't that what I heard?

Nancy Orvis – Director Health Standards Participation – Department of Defense

Yeah, Clem, this is Nancy Orvis. I mean that's what I usually say, its measures must be displayed in of the industry effects in the terminology relevant to that industry effective date or.

Jim Walker – Geisinger Health System

And what is the industry effective date?

Nancy Orvis – Director Health Standards Participation – Department of Defense

That means if it's after September 2013 you've got to use 10.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

This is Anne, that's not the case it's for dates of service.

Nancy Orvis – Director Health Standards Participation – Department of Defense

I mean for dates of service after October 1, 2013, any date of service after that has to have a 10.

Mariorie Rallins – American Medical Association

Right.

M

I've seen it that way if they tweak it but we don't have to rewrite our document.

Nancy Orvis – Director Health Standards Participation – Department of Defense

Right.

Jim Walker – Geisinger Health System

Great. And I'm, so, could Marjorie, could you give me that sentence again so we could get it, I'm sorry.

Mariorie Rallins – American Medical Association

Okay.

Jim Walker – Geisinger Health System

Being dense.

Mariorie Rallins – American Medical Association

Basically the final date of acceptability, I guess if that's...would be for dates of service I guess September 30, 2013.

W

Yes.

Mariorie Rallins – American Medical Association

For data, for quality measures that covered service no later than September 30, 2013, I mean that's what we're talking about right?

Jim Walker – Geisinger Health System

Okay, great.

Mariorie Rallins – American Medical Association

And then for dates of service starting with October 1, 2013 the transition vocabulary would be 10 CM.

Jim Walker – Geisinger Health System

Okay so the final date of acceptability would be dates of service after September 30, 2013.

Pam Cipriano, PhD, RN, NEA-BC, FAAN

Jim this is Pam. The service date before 2013 is actually stated by CMS. We were trying to figure out what is the acceptable lag time for reporting quality measures or was there a window that we should specify before everything needed to move to 10.

Jim Walker – Geisinger Health System

Right, but if you look up at that top line, I think we had, but we can change it, I think we had agreed that it would be services provided before October 1st or September 30th...

Mariorie Rallins – American Medical Association

Actually we already say that up there.

Jim Walker – Geisinger Health System

Yeah. So is the final date of acceptability is for reporting services after 09/30/2013.

Mariorie Rallins – American Medical Association

Before.

Jim Walker – Geisinger Health System

All right before. It's hard to, yeah the two don't.

Mariorie Rallins – American Medical Association

Maybe you don't even need that because the point is it's for dates of service before 10/01/2013 and I would think, I just don't know how far back you're going in your quality measures, but even, I mean if in 2015 you're reporting on activities in the first half of 2013 it still should be 9 CM not 10 CM because you haven't coded it in 10 CM. I don't think we should make people map from 10 CM to 9 CM. The mapping should be related to SNOMED not between the two transition codes.

Jim Walker – Geisinger Health System

Yeah, agreed. All right. I agree. All right, so final date of acceptability is dates of service before 09/30/2013; does that make sense to people?

Mariorie Rallins – American Medical Association

Before 10/01/2013.

Jim Walker – Geisinger Health System

Okay. And if someone has a thunderbolt about how to say that more clearly please let us know, but at any rate, I think we all know what we're talking about now. Are there any certification implications. Oh, well that date's hard. Is everyone comfortable with that logic for the date? So that you can't use 9 anymore for dates of service after October 1, 2013.

Pam Cipriano, PhD, RN, NEA-BC, FAAN

Jim this is Pam again. That's already specified by CMS and so I think what I'm hearing the conversation is that no one wants to put a terminal date for reporting quality measures if the service was provided before October 1, 2013. So the question will be, will that be acceptable long-term to ONC or CMS.

Jim Walker – Geisinger Health System

Right.

Mariorie Rallins – American Medical Association

Yeah well the next slide is a different issue, because 10 CM could be used for the foreseeable future but you probably don't, after 10/01/2013, but you don't necessarily want to be accepting it for all the time that 10 CM is in force.

Jim Walker – Geisinger Health System

Right. All right is everyone comfortable with slide 11 then? There are no relevant existing subsets and value sets. The mappings would be bidirectional SNOMED to 9, 9 to SNOMED, we just don't know what the readiness is until NLM gets the MU 2 measures. Sources would be Kaiser, NLM, commercial mappings, and others that may be identified. The final date of acceptability would be for dates of service before 10/01/2013. Any certification implications that anyone is aware of? All right. We'll call that none and go onto the next slide. So slide 12 ICD-10 CM, again Betsey is it the case here also that there's no relevant existing subsets and value sets or would that be relevant for 10?

Betsey Humphreys – National Library of Medicine

No. I would say that, yeah I would say that there isn't.

Jim Walker – Geisinger Health System

Okay. Is anyone.

Betsey Humphreys – National Library of Medicine

There is one in development, well it's not a subset where down to the mapping issue again.

Jim Walker – Geisinger Health System

Right.

Betsey Humphreys – National Library of Medicine

Yeah.

Jim Walker – Geisinger Health System

So is everyone comfortable, Chris any problem with saying no relevant subsets and value sets? All right. I'm going to take silence as an approval. So then mappings, what are the mappings that we actually need here then?

Betsey Humphreys – National Library of Medicine

I think for 10 CM, which is what we're talking about here you need SNOMED CT to ICD-10 CM and we need ICD-10 CM to SNOMED CT.

Dr. Asif Syed

Same as 9, same direction.

Betsey Humphreys – National Library of Medicine

Yeah both directions and.

Mariorie Rallins – American Medical Association

And not the mapping between 10 and 9.

Betsey Humphreys – National Library of Medicine

Yeah. And in this case there is a current project to map 10 CM, to map SNOMED CT to 10 CM and this is something that in effect Kaiser, which has already done some of this work and NLM are working on together now. So again, the issue of how close we are to what would be needed or how we could as quickly get to what would be needed first is dependent on this issue of exactly what pieces of SNOMED CT are going to be in the measures.

Jim Walker – Geisinger Health System

Right.

Andrew Wiesenthal – IHTSDO (SNOMED)

And Jim this is Andy. As to the date I'm a little confused about waiting until MU 3 because in fact, well I suppose we don't have to use SNOMED for the, you know, we already established we don't have to use SNOMED for the specs for measures until then right? So is that the reason for waiting then?

Jim Walker – Geisinger Health System

Well as I understand it 10 will be acceptable for MU 2.

Andrew Wiesenthal – IHTSDO (SNOMED)

Right, right.

Jim Walker – Geisinger Health System

But not for MU 3.

Andrew Wiesenthal – IHTSDO (SNOMED)

Right. Okay. Never mind, it's my answer to myself.

Jim Walker – Geisinger Health System

And there was some discussion last time that because 10 no organization can fail to make the deadline on 10 that's your whole business, whereas Meaningful Use would be what, well a couple of percent, something in that range of your business, and so a rational and even an organization that is trying fairly hard might get SNOMED in on time but then not start, get 10 in on time I'm sorry, but not start on SNOMED until then, and so I think the idea was that just being practical it might make sense to, although MU 3 does give us a hard stop doesn't it, it just says quality measures cannot be submitted in anything except SNOMED.

Mariorie Rallins – American Medical Association

What is the year for MU 3?

Jim Walker – Geisinger Health System

2015 I believe. Does someone know?

M

Correct 2015.

Mariorie Rallins – American Medical Association

So that should be the stop date I guess.

Jim Walker – Geisinger Health System

All right. Anyone have a problem with that?

Karen Kmetik – American Medical Association

Again this is Karen Kmetik just to say the dates for MU 2 and MU 3 are likely to evolve, so I just, it's hard to come up with the actual numbers of the dates but.

Jim Walker – Geisinger Health System

No, no you're right. On this one for sure I think we ought to just say the date that MU 3 is effective.

Karen Kmetik – American Medical Association

Right.

Jim Walker – Geisinger Health System

Right.

Mariorie Rallins – American Medical Association

So not a year after, but actually that date?

Jim Walker – Geisinger Health System

That date.

Mariorie Rallins – American Medical Association

Yeah.

Jim Walker – Geisinger Health System

Okay. So just to recap then other comments on no relevant subsets or value sets. We need mappings from 10 to SNOMED and SNOMED to 10. The readiness again is unknown until we get the information. The final date is the date that MU 3 becomes effective.

Christopher Chute – Mayo Clinic College of Medicine

Well this is Chris Chute. I am puzzled by that final date thing in that we give a year bi for ICD-9 CM, they can use that for a year after their supposed to be using ICD-10 for example.

Jim Walker – Geisinger Health System

Okay.

Christopher Chute – Mayo Clinic College of Medicine

But we're not giving the same bi on ICD-10, again being used in that context. Of course this all surrounds SNOMED readiness and penetration. So for MU 3 they'd have to be using SNOMED clinically anyhow is that the point?

M

Yeah that's the point. I think the reason for the persistence of 9 for some of the measures, and Chris you may be right if they argue for some allowance for 10 past the MU 3 effective date, is that their longitudinal so some data will be collected prior, so they'll be, as somebody talked before, they'll be dates of service that contribute to a measure that are prior to the effective dates for the 9 to 10 conversion, and we may have the same issue pre and post the final effective date of MU 3 for SNOMED.

Christopher Chute – Mayo Clinic College of Medicine

Exactly.

M

So we may have to give some leeway. I don't know exactly how and it also depends on the lead times for the various measures that are in question, so it's back to Betsey's conundrum if we know what the measures are we could make more sense here.

Jim Walker – Geisinger Health System

So Chris are you proposing then that the final date of acceptability would be dates of service before MU 3 becomes effective by analogy to 9?

Christopher Chute – Mayo Clinic College of Medicine

Well after MU 3 becomes effective right.

Jim Walker – Geisinger Health System

Yeah.

Christopher Chute – Mayo Clinic College of Medicine

In fact I'm actually suggesting that we go back to what's on the slide rather than what was said.

Jim Walker – Geisinger Health System

Okay and what was on the slide?

Christopher Chute – Mayo Clinic College of Medicine

Its one year after the MU 3 begins.

Jim Walker – Geisinger Health System

And you think that's better than dates of service in this case?

Christopher Chute – Mayo Clinic College of Medicine

Well I think it's better than the date of MU 3 starting, which is what I heard you say.

Jim Walker – Geisinger Health System

Right. Okay. Well, I just I didn't know if we could say dates and service here the way we did in 9.

Betsey Humphreys – National Library of Medicine

Well, I think that this is, I think that for the transition of ICD-9 CM and 10 CM.

Jim Walker – Geisinger Health System

Yes.

Betsey Humphreys – National Library of Medicine

That's a very relevant consideration but it seems less relevant to me for this one because the issue here is that whatever dates we have for, you know, whatever the final date is for requiring the Phase 3 Meaningful Use Quality Measures, a number of players may have devoted their resources to implementing 10 CM on time because they had to do that, and therefore they might like extra time to deal with SNOMED CT for the Meaningful Use Measures. Isn't that where you're coming from Chris?

Christopher Chute – Mayo Clinic College of Medicine

Yeah that's the crux of it.

Jim Walker – Geisinger Health System

Okay.

Betsey Humphreys – National Library of Medicine

And given that we don't know, if we knew for sure for example that everyone would have had to implemented 10 CM in years before we get to Meaningful Use Stage 3 measures then we might have a better notion of whether we were giving people too much time or not enough you know.

Jim Walker – Geisinger Health System

Yeah.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

Hi this is Anne and we're as an industry an insurance company, we're betting that not everybody is going to be up on 10/01/2013.

Betsey Humphreys – National Library of Medicine

It seems like a safe bet Anne.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

And we think it's going to be, you know, some time because we know the scope of work and a lot of providers have been working on the Meaningful Use and not even starting on the ICD-10 and the mapping is incredibly complex and difficult to do. And I also wanted to pass on that we expect a two year filing lag and I don't know exactly the source of all the information for the quality indicators, but there's a two year lag that we'll still be getting ICD-9 ins after people implement. So it's all rolling into that time period.

Andrew Wiesenthal – IHTSDO (SNOMED)

Yeah this is Andy. I'll just, I'll give a, I mean, I think it's just, it's safe to say there's a lot of confusion. Most of the organizations that we're dealing with are in fact sacrificing Meaningful Use and, you know, going full out on ICD-10 because that's how they get paid. They'd rather take a hit on incentives that they don't get. And, you know, I don't know whether they'll be ready or not. A lot of the speculation is that the big on readiness is going to be on the side of the payers, particularly the state Medicaid Agencies.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

I'll bet that.

Jim Walker – Geisinger Health System

All right. So that's an argument I take in favor of saying one year after MU 3 is effective.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

Is it possible to have an indicator of showing what someone is submitting, which code no matter what the effective date in the industry was if it's that important to this data?

Jim Walker – Geisinger Health System

I'm sorry I didn't understand.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

Is it possible that given the industry is going to have inconsistencies on implementation and with a date of service implementation that makes it worse? If there can be a code indicator that indicates what that submitter is submitting

Betsey Humphreys – National Library of Medicine

Anne I.

M

That actually is provided for in the uniform bill.

Betsey Humphreys – National Library of Medicine

I think, Anne I agree with you. I think they will have to do that because.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

Yeah. I do too.

Betsey Humphreys – National Library of Medicine

Because you'll have cases where you had data that was left over, cases where you didn't, yeah.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

Right. So that would be helpful if the precision was, you know, extremely important.

Dr. Asif Syed

So Jim this is Asif. So should this logic be applied to all the transition vocabularies minus ICD-9 CM? And date for one year after Meaningful Use 3.

Jim Walker – Geisinger Health System

Okay, so maybe, that's a great question Asif. Let's try to answer for 10. How many, well how are we going to do this? Is there anyone that doesn't think one year after MU 3 is effective is the appropriate final date of acceptability?

Betsey Humphreys – National Library of Medicine

I think it's the, this is Betsey, I think it's very acceptable for 10 CM.

Jim Walker – Geisinger Health System

Okay. Any. Just for 10 CM, absolutely. Just answering the question of 10 CM, is there anyone who thinks that is, that would put us somewhere in 2016, correct? Yeah.

Betsey Humphreys – National Library of Medicine

We don't know really but it might.

Jim Walker – Geisinger Health System

Well it wouldn't be any before 2016 put it that way.

Betsey Humphreys – National Library of Medicine

Yeah.

Jim Walker – Geisinger Health System

Okay. One last call, anyone who wants to speak against making the final date of acceptability of 10 only, one year after MU 3 is effective? All right. And readiness is unknown. And we just had the two mappings we believe 10 to SNOMED and SNOMED to 10. Certification implications? I'm sorry Jamie isn't here I don't know that I can represent in any useful way what he had in mind.

Betsey Humphreys – National Library of Medicine

Well, you know, the issue here is what are EHR products going to be certified to do right?

Jim Walker – Geisinger Health System

Right.

Betsey Humphreys – National Library of Medicine

And whether in order to be certified you have to be able to deal with these transition cases or not. And I know originally we were thinking that products would be certified, would have to be certified for the real target that we, you know, we want to get to.

Jim Walker – Geisinger Health System

Right.

Betsey Humphreys – National Library of Medicine

And possibly not for the transition.

Jim Walker – Geisinger Health System

Is that.

Betsey Humphreys – National Library of Medicine

Although one could argue that if you're not certifying that a product can adequately handle a transition you're leaving everyone who needs the transition to fend for themselves in terms of whether the product they have does it correctly or at all.

Jim Walker – Geisinger Health System

Yeah. I guess the counter argument to that would be that the transition vocabularies, except for 10, are already in use.

Betsey Humphreys – National Library of Medicine

Yep. So that they already are being handled in one way, shape or form. Yeah.

Jim Walker – Geisinger Health System

I think.

Betsey Humphreys – National Library of Medicine

And I think that's the way we were looking at it.

Jim Walker – Geisinger Health System

Any other comments on that? All right why don't we go ahead and try ICD-9 procedures then. I'm sorry.

Betsey Humphreys – National Library of Medicine

I would say that the information for 9 procedures would be identical as for 9 CM. I mean they're all 9 CM, but 9 diagnoses.

Jim Walker – Geisinger Health System

Okay. Does anyone see any problem with that?

Pam Cipriano, PhD, RN, NEA-BC, FAAN

No it should be the same.

Jim Walker – Geisinger Health System

All right. So we'll say. So Pam, 9 procedures will just be identical to 9.

Pam Cipriano, PhD, RN, NEA-BC, FAAN

Its 9 CM procedures.

Betsey Humphreys – National Library of Medicine

It is really.

Jim Walker – Geisinger Health System

Oh, thank you.

Betsey Humphreys – National Library of Medicine

And of course it isn't when we get to 10 CM, but hey, why are we trying to make life simple?

Pam Cipriano, PhD, RN, NEA-BC, FAAN

I'm game but it's not possible.

Jim Walker – Geisinger Health System

All right.

Betsey Humphreys – National Library of Medicine

Yeah right.

Jim Walker – Geisinger Health System

Okay so everyone's comfortable ICD-9 CM procedures will be identical to ICD-9 problem. All right then we're on slide 14 ICD-10 PCS.

W

I would think that should be the same as ICD-10 CM.

Jim Walker – Geisinger Health System

Okay. There's no billing wrinkles that would, no one is aware of any reason not to make this identical to 10 CM?

W

Sure.

W

I mean 10 PCS is just for inpatient or hospital measures. I mean you want, I mean in that sense, your, I was talking about the final date of acceptability. The description has to be a little different because it's only for hospital measures or inpatient measures whereas 10 CM is for, you know, both problem, well, I mean, it's for both hospital and outpatient, it doesn't, the 10 PCS use case is more constrained.

Betsey Humphreys – National Library of Medicine

And so is the 9 CM procedures isn't that.

W

Yes, well that's also true.

Betsey Humphreys – National Library of Medicine

Yeah. So we probably should somehow get that into better information that both of these are used for inpatient, right?

W

Yeah. I mean it says both 9 CM procedures and 10 PCS should specify value sets for hospital measures, for inpatient measures. So that isn't, but I was thinking of, you know, the date of acceptability.

Betsey Humphreys – National Library of Medicine

Yes.

Jim Walker – Geisinger Health System

So, just at the surface level of these slides what would be different about 10 PCS from 10 CM?

W

The first bullet, the existing subsets and value sets is only relevant for the inpatient measures.

Jim Walker – Geisinger Health System

Okay.

Betsey Humphreys – National Library of Medicine

Yeah. I would actually put it up right underneath.

W

I would say inpatient, I guess encounter intervention procedures.

Betsey Humphreys – National Library of Medicine

Yeah. I would put it right up there.

Jim Walker – Geisinger Health System

Oh, okay.

W

And the same with 9 CM procedures should say inpatient, no, yes 9 CM procedures should say the same inpatient.

Jim Walker – Geisinger Health System

Okay and then that will represent the difference and otherwise we can leave the slide be. The simpler this is obviously the easier it will be for other people to track what we're having trouble tracking.

W

And I guess, well the mapping from SNOMED CT to 10 PCS or vice versa doesn't have anything to do with ICD-10 because ICD-10 is only a disease or a problem classification. This ICD-10 PCS, despite its name is strictly a US classification.

Jim Walker – Geisinger Health System

And what are the mappings, the mappings would be the same we need for 10, just 10 to SNOMED, SNOMED to 10.

W

No nothing if it's 10, its SNOMED CT to 10 PCS and 10 PCS I guess to SNOMED.

Jim Walker – Geisinger Health System

Right. Okay.

W

In the previous one when you're talking about 10 CM, since it's based on an international classification 10, we do hope that the work of mapping between SNOMED CT to ICD-10 will contribute to the mapping then to from SNOMED CT to 10 CM, but there's no comparable situation with PCS.

Jim Walker – Geisinger Health System

Okay.

W

Makes sense?

Jim Walker – Geisinger Health System

Yeah.

W

I know it makes sense to Betsey, but, I don't know, it's just that 10 PCS is not based on a WHO classification as a US development.

Jim Walker – Geisinger Health System

Right. But in terms of the way the slide would read there's no relevant value sets or subsets, we need maps from 10 PCS to SNOMED, SNOMED to 10 PCS, the readiness is unknown. What about the date? Is the date?

W

That I would think would be the same as whatever you're saying for 10 CM.

Jim Walker – Geisinger Health System

Okay. In terms of certification implications?

W

Yeah. I don't know about that.

Jim Walker – Geisinger Health System

Anyone aware of any at any rate?

W

I mean this is something though that we did discuss maybe last call or the one before that and that is whether, if these transition vocabularies are allowed for a specified time period shouldn't products that are

being certified accommodate them during that time period? So that's where I think the certification implications are.

Jim Walker – Geisinger Health System

Yeah.

W

Because otherwise it's a false offer, you know, you can use this but the certified products won't allow it.

Jim Walker – Geisinger Health System

Well again, I think there's the asymmetry that the idea is that right now people are using 9, now 10 is a different question, but people are using 9, they know how to use it and so their vendor presumably has done something to keep them whole, and even with 10 the same thing would be the idea would be after October 3, 2013 your vendors figured out 10 and you have too because it's your whole business, but the question is whether, you know, there would be time or it would be reasonable to require in certification a mapping from 10 to SNOMED or SNOMED to 10. Any thoughts on that? All right. So we're going to, 10 PCS will, the words on the slide, except for the word inpatient will be identical to the words on 10 CM. And then we have CPT, that's slide 15. Are subsets and values sets relevant to CPT?

Marjorie Rallins – American Medical Association

Yes. So as I provide, this is Marjorie Rallins, there are subsets and value sets with...from the Meaningful Use round word work...work and we also used the...PQRS work as well.

Jim Walker – Geisinger Health System

Okay and then the readiness for it is a reasonable estimate of where they are.

Marjorie Rallins – American Medical Association

I believe it is.

Jim Walker – Geisinger Health System

Okay. Any thoughts or comments on that from anyone else? Okay. Yeah.

Betsey Humphreys – National Library of Medicine

This is just a question, Marjorie, so this takes care of the Stage 1 measures?

Marjorie Rallins – American Medical Association

That's correct.

Betsey Humphreys – National Library of Medicine

So, and that we presume will continue to be a subset of the measures that are also required for Stage 2 right?

Marjorie Rallins – American Medical Association

I presume that that is correct.

Betsey Humphreys – National Library of Medicine

Yeah. Okay fine. So in essence this is very relevant for a subset of what you have to do, for what you have to do now and a subset of what you'll have to do in the next stage.

Marjorie Rallins – American Medical Association

Yes.

Jim Walker – Geisinger Health System

Okay, now.

W

So should we qualify that encounter intervention procedure the way we did with the other two?

Betsey Humphreys – National Library of Medicine

Yeah.

Dr. Asif Syed

And then we have to specify for outpatient.

Betsey Humphreys – National Library of Medicine

Yeah.

Jim Walker – Geisinger Health System

So CPT is...

W

It's actually all physician services though.

Dr. Asif Syed

Yeah but that's true too.

W

I mean physician.

Dr. Asif Syed

Yeah also even if it's inpatient.

W

Even for inpatient will use this.

Dr. Asif Syed

Yeah that's correct.

M

CPT.

Jim Walker – Geisinger Health System

Okay so we'll leave it on, no adjective, we'll just say encounter intervention procedure. In terms of mappings we don't need CPT to SNOMED.

W

Yeah we do. This slide sort of predates our current discussions.

Jim Walker – Geisinger Health System

Okay.

W

And I would think we would need the reverse mapping.

Dr. Asif Syed

Pardon me, what would be the implication of the reverse map for this.

W

The same as for the I-9 and the I-10. You need to, for those that are starting with CPT, if they're, you know, transitioning to SNOMED then you'll need the other direction.

Jim Walker – Geisinger Health System

Why would you need SNOMED to CPT?

W

Well that's what currently exists.

Jim Walker – Geisinger Health System

Okay.

W

And that's why we, when you asked if do any maps exist, yes they do and, but the other question is we also believe we need the maps in the other direction.

Jim Walker – Geisinger Health System

Okay and that would be.

W

Kind of to mirror the 9 and 10 discussion.

Jim Walker – Geisinger Health System

So we'd need CPT to LOINC also? Is that what you're saying?

W

Yes.

W

Yeah that one's a little, that one's a little difficult, but.

M

I don't think that'll.

W

I think that one is hard.

Clem McDonald – National Library of Medicine

Well we're working on it, but yeah it is hard.

Dr. Asif Syed

What's the status, Clem, for this LOINC one, the update you're working on?

Clem McDonald – National Library of Medicine

I think something is done but I haven't seen it and I don't, something has been delivered to Dan.

Betsey Humphreys – National Library of Medicine

Yeah this happened very recently so.

Clem McDonald – National Library of Medicine

So I don't really know how you, you know, what kind of work it'll need and what utility you'll have because of the, so much is one code that goes, and actually it's from which direction was it, it was I think.

Marjorie Rallins – American Medical Association

It was LOINC to CPT but it was also an equivalence map, the one that I've seen, it wasn't rules based so.

Dr. Asif Syed

Yeah, it's same, Marjorie it's the same map it's just an updated version.

Marjorie Rallins – American Medical Association

Right so it's not a rules based map.

Dr. Asif Syed

No.

Betsey Humphreys – National Library of Medicine

I think what we should do is report back to people about exactly.

Clem McDonald – National Library of Medicine

What it is, yeah, yeah.

Betsey Humphreys – National Library of Medicine

The Regenstrief Institute recently, you know, acquired assistance in producing an updated version, you know, expanded version of something and I am not keeping the parameters of that at this moment.

Clem McDonald – National Library of Medicine

Yeah, it isn't the same as the other one, it's the other direction, the first one was from CPT to LOINC, this one is LOINC to CPT I think. But anyway, I think we both, we all need to kind of check and review.

Dr. Asif Syed

And the readiness will depend on where we are.

Jim Walker – Geisinger Health System

Yeah.

Betsey Humphreys – National Library of Medicine

We'll get an update on that.

Jim Walker – Geisinger Health System

All right so we have four mappings bidirectional CPT to SNOMED and bidirectional CPT to LOINC, and the readiness are as on the slide for the SNOMED to CPT and the LOINC to CPT. As to the readiness of the other two from CPT to SNOMED and CPT to LOINC are those both unknown or do we.

Dr. Asif Syed

Those are non-existent at this point.

Jim Walker – Geisinger Health System

Oh.

Mariorie Rallins – American Medical Association

Yeah. So the, we can't comment on the readiness.

Dr. Asif Syed

SNOMED to CPT is available right now.

Mariorie Rallins – American Medical Association

Well, I believe there are, you know, commercial CPT to SNOMED maps. I think people do that locally, we just can't comment.

Betsey Humphreys – National Library of Medicine

Yes.

Mariorie Rallins – American Medical Association

We haven't seen them. We can't comment on where they are.

Jim Walker – Geisinger Health System

All right. So unknown is a fair representation.

Betsey Humphreys – National Library of Medicine

And I will get the information so we have a more accurate picture of where we are on the LOINC side.

Jim Walker – Geisinger Health System

And then for the final date of acceptability for CPT, is ICD-10 going to replace CPT entirely?

Betsey Humphreys – National Library of Medicine

Not at all.

Jim Walker – Geisinger Health System

Not at all.

Dr. Asif Syed

ICD-10 for what?

Mariorie Rallins – American Medical Association

No it doesn't replace it at all.

Jim Walker – Geisinger Health System

So bills will be.

W

Those are kind of grosser categories than the ICDs, you know, procedure groupings are grosser billing categories.

Jim Walker – Geisinger Health System

Right. So what is the final date of acceptability?

Betsey Humphreys – National Library of Medicine

The final date of acceptability on this one would be an issue of what we think is giving people enough time to transition to SNOMED CT.

W

Right.

Betsey Humphreys – National Library of Medicine

Because they're going to continue to use CPT just as once they've made the transition and...PCS they will be continuing to use those for billing purposes.

Jim Walker – Geisinger Health System

So do we think one year after MU 3?

Betsey Humphreys – National Library of Medicine

I would say there isn't a reason to put a different date on it than you do for the ICD-10.

W

I would agree.

Dr. Asif Syed

Like a couple more years then?

W

No it could be the same as 10.

Jim Walker – Geisinger Health System

So we're saying one year after MU 3 is effective is that correct?

Betsey Humphreys – National Library of Medicine

Yes.

W

And keep in mind this is within the reporting of quality measures, it's not with respect to reporting claims, CPT continues to be, will continue to be used for that purpose.

Betsey Humphreys – National Library of Medicine

Yeah, it's the same as 10 CM and so forth will be.

W

Right.

Betsey Humphreys – National Library of Medicine

Yeah.

Jim Walker – Geisinger Health System

Right. Okay. And implications of, certification implications, anyone aware of any? All right I'm not going to recap all that. I think we have a pretty agreement. Any other comments on CPT? All right HCPCS. Last slide. We have nine minutes before public comment. Okay subsets and value sets, are they relevant to HCPCS?

Dr. Asif Syed

I don't think.

Jim Walker – Geisinger Health System

Does anyone believe that we need.

M

Someone was trying to, I thought we thought that they might be, some of them might be, someone I thought was going to check with CMS, but, the last question I thought, somebody thought they might be.

Jim Walker – Geisinger Health System

Does anyone on the call have any idea of why they might be?

Betsey Humphreys – National Library of Medicine

I do not.

W

Marjorie Rallins did you know about that or?

Marjorie Rallins – American Medical Association

No I don't. The only thing I know is that I provided the information and we have about 5 value sets in development in Meaningful Use Stage 1 that's all I can provide. I don't know where the readiness came from.

Jim Walker – Geisinger Health System

Okay and as far as mappings, what mappings would be needed?

W

Are there mappings, Betsey, being undertaken with HCPCS?

Betsey Humphreys – National Library of Medicine

No none that I am aware of. Generally, and I think I'm correct about this, but I am not a HCPCS expert, I think that, you know, we chose that these things have been used as supplies and in a variety of different things so I guess that a question that we would have is, I don't know Marjorie, you used some of the measures and I should have studied the ones you've used them for but I haven't done it yet. I mean are these things that you would expect to feature in a quality measure to enumerate in some other vocabulary?

Marjorie Rallins – American Medical Association

Yeah, that's, I mean this is where the original regulation was silent and so we used HCPCS, but we also had companion value sets in other terminology.

Jim Walker – Geisinger Health System

So are we saying that we have identified no relevance of mappings for HCPCS? Is anyone aware of any relevance of mappings from HCPCS to anything or back? All right. I'm trusting you're going to speak up if someone has something.

Marjorie Rallins – American Medical Association

Well, I mean, conceivably if someone can only use HCPCS and not, you know, SNOMED, conceivably you could have a map in either direction. I just don't, I can't think of any particular instance in where that, you know, I mean that could happen.

Jim Walker – Geisinger Health System

Okay. Well that's, I mean if no one on the call can identify I think we'll probably take it to the Standards Committee with that information and see if someone on this committee can identify a relevance. So for final date of acceptability are we back to one year after MU 3 is effective or is there some different set of conditions here?

Betsey Humphreys – National Library of Medicine

Marjorie do you know what, or does anyone on the call know what, if any expectation there is within CMS of sun setting HCPCS?

Marjorie Rallins – American Medical Association

You're asking the other Marjorie, correct?

Betsey Humphreys – National Library of Medicine

I am, yes.

Marjorie Rallins – American Medical Association

Okay. Good.

Marjorie Greenberg – Health & Human Services – Center for Disease Control

Well I thought you were asking the other Marjorie. All right. What was your question?

Betsey Humphreys – National Library of Medicine

My feeling is that is there a discussion, and maybe I just pick up the phone and quickly try to check in with Karen or whomever she points me to at CMS, is there not some long-term plan to get rid of HCPCS?

Marjorie Greenberg – Health & Human Services – Center for Disease Control

I don't know. Donna might know, but I haven't actually heard that.

Betsey Humphreys – National Library of Medicine

All right.

Marjorie Greenberg – Health & Human Services – Center for Disease Control

I mean, unless, and you mean to replace it by what, SNOMED?

Betsey Humphreys – National Library of Medicine

Well, you know, of course we had HCPCS for drug codes in HIPPA and those were replaced by NDCs.

Marjorie Greenberg – Health & Human Services – Center for Disease Control

Right.

Betsey Humphreys – National Library of Medicine

And I suspect that there is a desire going forward to get to a more granular device coding system than HCPCS. And then the issue is what's left.

Marjorie Greenberg – Health & Human Services – Center for Disease Control

Yeah it's a bit arcane. I'm trying to think who the HCPCS person is because it's not, it's somebody else, it's not Pat Brooks.

Betsey Humphreys – National Library of Medicine

Well, I guess what I got to do is I will attempt in the next day to, you know, ASAP, to find that, you know, get a high level view of this. My sense would, because certainly issues related to drugs are very important but now the HIPPA code set is NDCs and it was HCPCS before.

Jim Walker – Geisinger Health System

And again, this is only in the context of quality measures. I don't believe HCPCS has any place in the QDM spreadsheet.

Betsey Humphreys – National Library of Medicine

In what?

Jim Walker – Geisinger Health System

I don't think HCPCS is a standard vocabulary for any of the quality data model concepts.

Pam Cipriano, PhD, RN, NEA-BC, FAAN

Jim this is Pam. I was NQS staff who identified that HCPCS should be one of the six transition sets; we may need to check back with them for the specific areas.

Jim Walker – Geisinger Health System

Okay.

Marjorie Greenberg – Health & Human Services – Center for Disease Control

Sounds good.

Jim Walker – Geisinger Health System

Pam can you do that?

Pam Cipriano, PhD, RN, NEA-BC, FAAN

Sure.

Jim Walker – Geisinger Health System

All right. So right now at least we're not aware of any relevance to subsets or mappings. We don't really have any clear idea of what the final date of acceptability would be or do we think it would be one year after MU 3? No thoughts on that one. We should just say unknown? Okay. And who is going to look into this, Betsey did you say you were going to talk to Karen?

Betsey Humphreys – National Library of Medicine

I'm going to see if I can get Karen Trudel or somebody she refers me to, to get a high level CMS view of what they expect to happen to HCPCS over time.

Jim Walker – Geisinger Health System

All right. So maybe we're better off. If you can find something out that quickly that would be great and if not Wednesday we'll just say we're still looking into HCPCS. All right. We have 1 minute before public comment. Any other thoughts, anything else that we need to make sure we get right? We'll try to get the slides out tonight since that's the form you've looked at them in and have, ask you to, if you have a chance at all to look at that and catch anything we got wrong so that we can take a pretty clean report to the Standards Committee on Wednesday. And Judy I guess we're ready for, thank you all very, very much, and Judy I think we're ready for public comments.

Judy Sparrow – Office of the National Coordinator – Executive Director

Operator can you check and see if anybody does wish to make a public comment please.

Alan Merritt – Altarum Institute

If you'd like to make a public comment and your listening via your computer speakers please dial 1-877-705-2976 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue. We have one public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay. Please go ahead and identify yourself.

Carol Bickford – New York Nurses Association

Carol Bickford at the New York Nurses Association. I apologize for not being on the call at the beginning of the discussion but I'm inquiring about the decision making based on the recommendations that come forward from this committee, will that action occur at the upcoming conference, the upcoming standards meeting or is there still work ahead?

Jim Walker – Geisinger Health System

This is, oh, thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director

I think we're hoping it'll happen on Wednesday, correct Jim?

Jim Walker – Geisinger Health System

I think for the first five there is a pretty good chance that the Standards Committee will regard it as actionable and final. HCPCS I wonder if we'll be confident enough by then that they'll be able to take that same kind of stance, we'll see.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay. Thank you. Any other questions from the public.

Alan Merritt – Altarum Institute

We have no further comments.

Judy Sparrow – Office of the National Coordinator – Executive Director

Talk to you later.

M

Thank you.

Jim Walker – Geisinger Health System

Thank you all. Take care.

M

Bye-bye.

W

Bye.